

THE LIVED EXPERIENCE OF FEMALE NURSE GRADUATES OF  
INTERPROFESSIONAL EDUCATION TRANSITIONING TO CLINICAL PRACTICE

by

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## ABSTRACT

### THE LIVED EXPERIENCE OF FEMALE NURSE GRADUATES OF INTERPROFESSIONAL EDUCATION TRANSITIONING TO CLINICAL PRACTICE

Michelle McFee Romano

The need for nurses to be collaborative and practice-ready upon entering the profession has never been more important than it is today. The Institute of Medicine has identified that teamwork and collaboration should be essential parts of the nursing curriculum to prepare nurses to be ready to manage patient care with a team-based approach. The literature supports the idea that by learning out of silos and bringing students together from all different pre-professional programs, the professional working environment can be mirrored and the processes of collaboration and communication within teams can start.

Transition into practice has been studied for decades regarding the “burnout” and “reality shock” that result from the experience. However, no literature has been uncovered that has investigated the nurses’ experiences of transitioning into practice after receiving an interprofessional education. The present study used Merleau-Ponty’s phenomenological perspective and vanManen’s phenomenological research method to illuminate the experiences of nurses transitioning into practice after having IPE. Ten

practicing nurses who had received IPE were interviewed about their experiences transitioning into practice. Each participant shared stories about her transition period into professional practice. Through the process of reading and rereading transcripts, four essential themes emerged that shed light on the transition into practice after receiving IPE: (a) Understanding Team Dynamics, (b) Competent and Responsive Communicators, (c) Valuing Team Members, and (d) Recognized Self-Readiness. For this study, the lived experience of nurses who transitioned into practice after receiving an education with an IPE curriculum and practice is one of understanding team dynamics as competent and responsive communicators, valuing team members, and recognizing self-readiness.

Interprofessional education does not have to occur only with students in nursing, medicine, or other allied health programs. Being creative with multiple programs at any institution can enrich students' education by developing their communication and collaboration skills and adding quality and scope to their education experiences while preparing them for the real-world environment.

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## DEDICATION

I would like to dedicate this study to the profession of nursing of which I am so proud to be a part. To all the nurses who are coming up, those who aspire to be leaders, administrators, and educators and want to make change, I dedicate this work to you. I hope this research inspires you to bring interprofessional education into your classrooms, collaborative practice, and all aspects of your work. I wish you an amazing career in the most wonderful profession I know.

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M. M. R.



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## Chapter I

### INTRODUCTION

*A new graduate nurse, Dorothy, is about to begin her orientation at a local community hospital and start her first day on a medical-surgical unit. Dorothy has been educated in an interprofessional education (IPE) program collaboratively with students from other disciplines like medicine, occupational therapy, physical therapy, pharmacy, and social work who take classes and care for patients together to develop their team skills. On the first day of orientation, Dorothy is about to start her professional journey as a registered professional nurse with help from her nurse preceptor. She takes report from a night shift nurse who gives the run-down of patient information and care patients have been receiving. Once report is completed, the new graduate nurse makes rounds on her patients, doing a quick surveillance of the environment and introducing herself. As Dorothy begins to prepare her notes and identifies ways the team will be incorporated into the care of her patients, she asks her nurse preceptor, "When will the team be making grand rounds?" The preceptor explains, "We don't really do rounds with the other healthcare disciplines here on this unit, but if you have any questions, let me know." The new nurse is confused as this is not the way she learned how to care for patients. While in one of her patient's rooms, Dorothy introduces herself to the third-year medical resident and begins to explain that she identified a potential need for physical*

*therapy due to the patient's lower extremity weakness. The doctor appears put off and states, "I'll do an assessment and decide what the patient needs." Dorothy is shocked and puzzled by the lack of respect for her role and the realization that a collaborative team effort will not be in place—which was not how she was educated to approach her work. The new graduate nurse feels deflated and undermined by this exchange. Her transition from IPE suddenly seems unrelated to this new work environment.*

The anecdote above illustrates one account of a transition from IPE to a clinical setting—the phenomenon to be studied in this research—that I thought I might have heard during the interview process, but I did not. In fact, the nurses I interviewed had quite the opposite experience. The stories and experiences that were brought to light described collaborative exchanges between healthcare professionals and were aligned with the competencies within all IPE curriculums.

The context for this phenomenon was female graduate nurses who experienced IPE and were entering clinical settings that may or may not follow the concepts of interprofessional collaboration and patient care practice. The rationale for choosing female nurse graduates was primarily because more than 90% of nurses working within the profession are female (Human Resources Services Administration [HRSA], 2010); a male nurse may have a different experience and understanding his experience may require a different study.

Historically, nursing programs have developed and educated nurses in silos. In education, silos refer to cohorts of students who share the same major/curriculum and learn together (Clancy & Thornber, 2007). Silos have been and continue to be the traditional way nursing students and many healthcare professionals are educated—in

cohorts among students within their own discipline. In silos, students develop an understanding of their professional scope of practice. Nursing students learn together and study together to gain an understanding of the nursing process and develop clinical skills together in simulation labs and hospitals. Upon graduation, however, the healthcare team providing patient care is not composed only of nurses, but also of many healthcare professionals. According to Speakman and Arenson (2015), the silo learning environment will have “unintended consequences” because students who learn in silos will not have the opportunity to practice necessary skills that align with today’s public health needs. Thus, a more realistic way of educating healthcare professionals to meet healthcare changes and to be practice-ready is interprofessional education. IPE experiences provide nursing students with opportunities to learn with other healthcare professionals, out of silos and thus matching the current healthcare demands of today (Institute of Medicine [IOM], 2013). By definition, IPE is an experience that “occurs when students from two or more professions learn about, from, and with each other” (World Health Organization [WHO], 2010, p. 3). During IPE, students are taught how to collaborate as professionals in an environment that mirrors where they will ultimately be working; it is experiential learning. The IOM (2013) explained experiential learning as the practice of students who enter a learning environment together to understand better how to work collaboratively in “real-life” situations.

There is a need for highly qualified healthcare workers to transform patient care for the future. Unless graduates receive the type of education to make them “work-ready,” healthcare workers will be unable to transition into the “organizational culture” and will not contribute as nurses to a collaborative environment because they have little



to no teamwork capabilities (Stone, 2010, p. 396). The transition period from student nurse to graduate nurse in clinical practice has been widely studied and also recognized as a period of stress, role adjustment, and reality shock (Casey, Fink, Krugman, & Propst, 2004). Casey et al. explained how new graduates do not feel “skilled” and lack “confidence” while transitioning from their familiar educational environments into their new work environment. According to the IOM (1999, 2011), critical thinking skills, collaboration, teamwork, and leadership are necessary requirements to assure safe and effective patient care. Education that focuses on an interprofessional learning environment will teach the competencies necessary for being practice-ready in the healthcare workforce (WHO, 2010). Teamwork and collaboration are strongly emphasized, in conjunction with evidence-based practice, quality improvement, and informatics, to assure safe patient-centered care.

The phenomenon of interest for this study was new nurses transitioning into practice, and the context was graduate nurses who have completed interprofessional education (IPE) and are entering clinical practice. The purpose of this study was to illuminate the meaning of transition to practice by nurses who have graduated from a school with a philosophy and curriculum of IPE. Practicing nurses were asked to reflect on the experience of transitioning to graduate nurses. Their reflections will provide insight into the experiences of nurses transitioning from an educational program steeped in IPE and then entering a healthcare setting as graduate nurses.

### **Aim of the Study**

The aim of this research was to explore the lived experiences of graduate nurses and their transition into the professional role after graduating from a nursing program that offers an interprofessional education (IPE). To ground this study, van Manen's (1990, 1997, 2014) phenomenological method was used. One beginning question with follow-up questions based on participants' responses were used to explore and understand the phenomenon and develop a clearer view of the experience of graduate nurses with an IPE-focused education who were transitioning into their professional role after receiving an IPE.

### **Phenomenon of Interest**

#### **Transitioning Into Practice**

The phenomenon of transition into practice is not new. The transition of graduate nurses into practice has been widely studied for decades beginning with Kramer (1974) and remains a topic of interest today (Chandler, 2012). As a central concept in nursing, transition has been defined as a passage or movement from one state, condition, or place to another (Chick & Meleis, 1986). Transitioning from graduate nurse into a professional role has been also identified as "transition shock." Marlene Kramer (1974) wrote about this in her book *Reality Shock: Why Nurses Leave Nursing* and described reality shock as "the work situation as perceived, experienced, and shared by groups of nurses" (p. 9). She described the experiences of nurses who are dealing with transition and the shock they feel when "school-bred values conflict with work-world values" (p. 4). The first year of practice for graduate nurses is a difficult one and, given healthcare's increasing demands,

the transition into practice has now become imperative to explore today. Kramer described new graduates as “excited” and “enthusiastic” during the honeymoon phase of first entering a new work environment, but who then become “disillusioned” because of a lack of confidence soon after the orientation. She further explained that nurses who are in conflict within themselves “will experience difficulty in relation to patient care” (p. 219). In addition, Chandler (2012) indicated that during their first year, new graduate nurses have reported experiencing an overwhelmed feeling, being fearful of physicians, and finding it difficult to prioritize and delegate responsibilities. Thus, difficulty transitioning, lack of confidence, and disillusionment about the profession and facing a new “reality” are some of the experiences nurses have undergone during the transition period into graduate nurses. How they manage to work through this time can profoundly affect their career within the profession.

The unintentional consequence of new graduates feeling overwhelmed during the transition phase has been correlated with the reality of graduate nurses being deployed too quickly into practice (Dyess & Sherman, 2009). Many new nurses feel the magnitude of their responsibilities and how they believe they lack “knowledge and skills” to meet the demands of their new role (Schumacher & Meleis, 1994). The expectations for new graduates to function rapidly as competent nurses has only caused many of them to feel inadequate and unprepared to meet the high demands of patient care (Casey et al., 2004). The unfortunate consequence that new nurses are having relates to their difficulty with role transition due to lack of confidence, frustration with the work environment, and an inability to communicate with physicians. This ultimately may cause nurses to feel

incompetent to render safe and effective care to their patients and thus they want to leave the profession.

Although research has been conducted on how graduate nurses transition into practice from traditional nursing programs, no research seems to be available on IPE graduate nurses transitioning into clinical practice. For the purpose of this phenomenological study, the experience of transitioning into the role as a graduate nurse after completing an IPE experience was studied.

### **The Context for the Phenomenon**

The phenomenon of interest was transitioning into practice and the context was the experience of a graduate nurse after attending a nursing program with the curriculum and related practice based on interprofessional education (IPE). Much of the research on transition into practice as new graduate nurses has reflected on traditional nurse graduates and their experiences during this initial stage. In looking at transitioning into practice throughout history, the focus has been on the difficulties of transitioning into practice for these new graduate nurses who have graduated from traditional nursing programs.

Several strong recommendations are in place to integrate changes that will help resolve the factors producing ineffective transitioning. Research has strongly suggested the need to bridge the learning from student nurse to graduate nurse in practice (Duchscher, 2009). The nursing profession greatly benefits from preparing new graduates for a smooth transition into practice because it “improves retention, job and practice satisfaction, improved performance, and reduction in environmental reality shock...” (Kramer et al., 2012, p. 157). Many hospitals have implemented a residency program that offers new graduates a 1-year program focused on the clinical area of specialization

(Goode, Ponte, & Havens, 2016). Moreover, much has been done to implement these programs by offering longer orientations and internships to remedy the transition period successfully. However, as noted, no research to date has examined how graduate nurses transition into practice from their IPE experience.

The IOM (2011), the WHO (2010), and the Robert Wood Johnson Foundation (2010, 2013) have all strongly recommended that nursing education implement IPE in order to meet the demands of safe, high-quality, and patient-centered healthcare service and prepare nurses to fulfill their expanding role (IOM, 2011). IPE has been defined as occurring when students from two or more professions learn about, from, and with each other (WHO, 2010). The WHO has also recommended that healthcare professionals be practice-ready when they enter the workforce. With IPE, students learn to collaborate and communicate effectively, and by doing so, they develop leadership qualities and mutual respect for one another's knowledge and skill sets (Interprofessional Education Collaboration [IEPC] Expert Panel, 2011). Many of the difficulties during transition that have been noted in the literature are worked through in the formative years during an IPE experience, such as forming a team approach to patient care, developing respect for other professions, and collaborating. However, IPE may or may not be related to the implementation or understanding of "team work" as well as hierarchal decision making within the healthcare team. Having ambiguous lines of power often causes confusion over strategic planning within the interprofessional teams (Reeves et al., 2011). Reeves, Lewin, Espin, and Zwarenstein (2010) noted how the inequality within interprofessional healthcare teams can be misleading and must be managed daily to have a successful collaborative team approach in patient-centered care. The research has also explained

how leadership within the teams is complicated because the flexibility necessary for changes in leadership roles due to patient needs can be problematic when there is more inflexible medical dominance over care.

The IPE experience is designed to bring professional healthcare students together to learn and engage in collaborative, patient-centered care (Reeves et al., 2011), sometimes requiring modifications in leadership within the team. However, to date, no research has provided insights into how nurse graduates transition into practice or where the clinical environment may or may not have implemented the patient care principles compatible with IPE. To my knowledge, no available research has yet explored the lived experiences of IPE nurse graduates and their transition into their new role.

This current study qualitatively investigated the lived experience of the transition of graduate nurses into practice after graduating from an IPE program in order to illuminate how this education has impacted their transition and clinical practice.

### **Justification for the Study**

Research has suggested that functioning interprofessional healthcare teams improve quality of care and patient outcomes. According to the Josiah Macy Jr. Foundation (2010), this type of care is imperative not only for the patient receiving this high-quality effective care, but for those who are delivering the care and expressing increased job satisfaction. Exposing nursing students to the team approach while they are learning their roles for the future is the rationale behind IPE. The IOM (2010) explained why collaboration is necessary by stating that the precursor to clinical competence begins with the philosophy of the education. “Collaboration requires shared understanding of

goals and rules, shared decision-making, and conflict management. Students need formal experience with collaboration so that they can receive support and guidance from faculty” (pp. 99-100). The Josiah Macy Jr. Foundation (2013) also explained that by educating, training, and developing an environment of lifelong learning, healthcare workers can become connected. From the Foundation’s Conference Recommendations in January 2013 came this important conclusion about the value of IPE:

Making this important linkage between interprofessional education and collaborative practice will create an environment within which all participants learn, all teach, all care and all collaborate. It invites recognition that better outcomes for individuals and populations; better quality, safety, and value within healthcare systems. (p. 1)

According to the IEPC Core Competencies (IEPC, 2011), interprofessional learning is designed to prepare health professional students to have a common goal, which is to be ready to work as part of a patient-centered care team. This true collaboration is viewed as the priority for the community and national population.

As a prerequisite to this goal, healthcare educators and administrators need to keep in mind the challenges of transition, as documented in nursing. Kramer (1974) found that many new graduate nurses left the profession as a result of their inability to bridge their knowledge from the student nurse role to the graduate nurse role. New graduates expressed feelings of being “overwhelmed” and having “unmet expectations” of the profession. The uncertainty of their role during transition is due to the need for new knowledge and skill development during the transition phase (Schumacher & Meleis, 1994). IPE creates a pre-profession learning environment that provides opportunities for nurses to engage with other disciplines, builds confidence, and offers students the chance to care for patients in a collaborative team environment (Buring et al., 2009). Preparing

professionals to work in teams during the “pre-professional” stage provides an environment with certain expectations of interprofessional relationships. Thus, it is important to understand the transition of graduate nurses from an IPE curriculum to the graduate nurse role in a clinical setting so that these graduates do not leave nursing.

### **Assumptions, Bias, and Experiences**

Van Manen (1990) explained that before we understand a phenomenological question, we already have assumptions of the phenomenon because we know too much about it to begin with. Husserl (1970) offered the idea of bracketing to “take hold of the phenomenon and then place outside of it one’s knowledge about the phenomenon” (p. 175), which allows researchers to separate what is being studied from their predisposed knowledge. According to van Manen (1990), it is impossible to remove one’s bias or the belief that there is enough information known about the topic of interest. He concluded that we all come to a belief of something and have a pre-understanding of things because we have been exposed or predisposed to the nature of the phenomenon before we start our investigation.

Transitioning into roles—specifically, the graduate nurse transitioning into the professional role—has been studied since the 1970s. Most nurses are educated in traditional programs built around silos; they develop skills and competencies as well as clinical development together in a cohort-like setting. As an educator in a traditional baccalaureate nursing program and having come from the same traditional background, I would not have understood the differences between an IPE program and a traditional program. However, I worked in an interprofessional environment as a staff nurse and



understand the level of collaboration and communication that this type of environment enriches. I believe that student nurses who come from an IPE environment will have the ability to transition smoothly because they will have developed the ability to understand the roles of other disciplines and understand the team-based collaborative approach to patient-centered care. I also think the experiences of IPE graduates going into clinical situations where IPE is not valued or practiced will talk more about “reality shock” because the work environment will not have matched or valued their IPE experience.

Because IPE brings other disciplines together to learn and work together collaboratively, I assume that these new graduates will be able to express their lived experience in an honest and professional way. I also believe that these shared reflective experiences can illuminate an understanding of their transition after an IPE program and entering the profession and if there is continuity between the experiences. Finally, I believe there is value in understanding how their education impacted transitioning into their new role as professional registered nurses and if the education matched the work environment. This study was limited to female graduate nurses after undertaking IPE.

### **Selection of Phenomenology With Justification of Its Potential**

The goal of phenomenological research illuminates the meaning of the lived experience and gives meaning to the perceptions of that experience (van Manen, 1990). Identifying the impact of transitioning into practice after graduating from an IPE program was the phenomenon and its context that were studied. According to Merleau-Ponty (1945/1965), our reflection and the opportunity to focus on the experience “objectify our point of view or perspectives” (p. 344). Through an analysis of themes, this research will

provide nursing educators and administrators with an understanding of the lived experience of graduate nurses who graduated after completing an IPE and transitioned into the professional role. It is essential that the healthcare profession understand the impact of the educational experience on the transition to practice. The purpose of this research, then, was to provide insight into this team-based, collaborative, patient-centered IPE curriculum and its influence on transition into the practice of graduate nurses.

### **Significance of the Study**

The purpose of this research was to understand the transition of graduate nurses after having an IPE experience. Transition into practice has been widely studied and much is understood regarding its challenges and pitfalls, as well as ways to remedy this difficult time. Over the past several years, the IOM and the American Organization of Nurse Executives (AONE), along with other professional organizations, have strongly advocated for residency programs to bridge the transition period from graduate nurse to professional role (Kramer et al., 2012). Although residency programs provide a great transition opportunity for new graduate nurses, they are few and far between for new graduate nurses.

With growth in technology and changes in healthcare happening at an accelerated rate, nurses, unlike other professionals, are not often offered a transition program as they enter their chosen profession (Spector et al., 2015). Some evidence has suggested that a successful transition today is more critical than ever before because of the rising acuity rate of hospitalized patients. Despite this need, however, orientations for new graduates are shorter to expedite new staff into their professional roles (Dyess & Sherman, 2009). If

IPE offers new graduate nurses a better transition into practice, then incorporating IPE into the nursing curriculum could be cost-effective and support the Institute for Healthcare Improvement (IHI's) Triple Aim initiative to improve the quality of patient care that is delivered by healthcare teams (Stiefel & Nolan, 2012). The focus of the Triple Aim is to look at: the quality of the care delivered by healthcare teams and ensuring it is safe and effective; the cost of care, i.e., the total cost of care and measures that drive cost; and the overall experience, not only of the patient but also of those delivering the care, all because of the realization that the "team approach to patient care has overall better outcomes" (Brandt, Lutifiyya, King, & Chioreso, 2014, p. 393).

Research has identified that difficulty during transition into nursing practice is "directly correlated with low retention rates, premature termination of their first position, and or leaving the profession all together" (Chandler, 2012, p. 103). Bowles and Candela (2005) noted that nurses with negative job experience soon leave their positions, wasting orientation resources and cost. Providing training and development for future healthcare providers (such as nurses) with an IPE experience will ensure their ability to enter into practice and have improved job satisfaction and retention rates because they can "understand the roles of the team and how to manage patient care using a team model" (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011, p. 2). Unfortunately, all of the above research on transition into practice was conducted with traditional nursing graduate nurses in mind. No research has explored nurse graduates who transition after having an IPE experience, and the present research sought to fill that gap.

IPE offers the benefit of teaching diverse health profession students to work in teams, collaborate, communicate, and understand each other's roles and responsibilities

(Pardue, 2013). A team-based model has been directly correlated with higher quality of care and better patient outcomes (WHO, 2010). The key concepts for the IPE curriculum, as described by Pardue (2013), are “teamwork, collaboration, communication, respect, problem solving, conflict resolution, and knowledge of roles, reflection/personal awareness and ethics” (p. 98), which are central to IPE learning. Educating healthcare professional students during their formative years may yield practice-ready healthcare providers who are able to transition well and collaborate and communicate effectively in order to deliver high-quality team-based care. Considering the type of curriculum and development that a student in an IPE environment receives, it would be of great interest to explore the transition into practice for this new graduate nurse and whether practice does or does not match the IPE philosophy.

### **Significance for Nursing**

Teaching methods to develop the next generation of nursing excellence provide an ongoing challenge (Murray, 2013). Nursing faculty is making every effort to contribute the most innovative curricula to the classroom while also trying to meet the demands of changing healthcare needs. Simulation labs with high-fidelity equipment bring the “real patient” to life, and concept mapping and case studies build a deeper understanding of the nursing process and critical thinking. Clinical experiences take students from the theoretical experience of the classroom into the real world of the nursing profession. Although students have access to both conceptual and reflective learning, faculty still struggle to make sure they are delivering enough if the nursing curriculum of a traditional program is content-based (Benner, Sutphen, Leonard, & Day,

2010). Thus, IPE offers the opportunity to learn with and from other professional students and engages them in a better understanding of each other's roles within the healthcare team (WHO, 2010). Perhaps this form of learning will match the work environment and start the conversations necessary to bring more IPE into every learning environment. However, if the work environment does not match the IPE experience, this information could greatly influence changes within the current IPE curriculum as well as hospital orientations.

Traditional nursing programs are taught in silos, in cohorts of students all learning together. Nursing students attend clinical rotations and labs together, with no time to learn with or from other healthcare professional students, even within their own colleges and universities. This segregation is due to many barriers such as “scheduling, rigid curriculum, turf-battles, and lack of perceived value in an IPE education” (Gilbert, 2005, p. 89). Students of professional programs continue to coexist in their silos across many colleges and universities, without the disciplines ever collaborating. By contrast, IPE experiences bring multiple cohorts of health professional students together to learn in teams, based on the incentive that this type of education will build a foundation for the real-world experience of teamwork and foster interprofessional collaboration. Gilbert explained that language and the use of the word “interprofessional must start with the professionals who are teaching first in order to overcome the many barriers to IPE” (p. 90).

Furthermore, understanding the experience of transition for IPE graduate nurses can provide insight into IPE, the curriculum, practice, and the transition itself. Exploring this experience can benefit other cohorts to understand the transition of their specific

discipline into practice as well. Insights into the types of nurses these IPE nurse graduates become is significant to nursing. If we want to be leaders in our field and meet the demands and expectations of the IOM recommendations for 2020, which are advancing practice and doctoral-prepared nurses, this study is necessary.

### **Summary**

This chapter introduced the phenomenon of transition into practice, within the context of being a new graduate nurse who has experienced an IPE program. It also introduced the qualitative research method and identified the assumptions and bias of the researcher. The significance of the study, particularly for nursing, was outlined. This chapter concluded by identifying the need for further study of the transition into practice from the perspective of other disciplines within IPE.

Chapter II next presents the historical background of gender roles in society that have played a part in the difficulties inherent in professional roles and professional practice. Team-based patient-centered care are explored to understand the need for IPE in healthcare professional programs. Finally, transition into practice is examined as the phenomenon that was researched in this study.

## Chapter II

### EVOLUTION OF THE STUDY

#### **Gender Roles/Historical Perspective**

The profession Miss Nightingale envisioned was an administrative and custodial equal with the medical profession, with independent authority and training. Nursing was to create an environment within which effective medicine could take place. Ultimately, however, the vision proved unacceptable to the medical profession, partly because of the interprofessional relations implied, partly because Miss Nightingale was unable to find enough of the proper recruits necessary. The result, familiar enough today, was the subordination of nursing under medicine. (Abbott, 1988, p. 71)

#### **Professionalism and Gender Inequality**

The conceptual idea of professionalization, as explained by Friedson (1970), is a strategy to gain occupational control. Historically, professional groups concerned about losing their “status” wanted to gain control by guarding their knowledge, which they did by regulating entry into the profession. In his book *Medical Power and Social Knowledge*, Turner (1995) explained that the strategies for professionalization were the “production and maintenance of esoteric knowledge” (p. 139) so that only a select population would be able to enter the medical field, competitors would be removed from the marketplace by providing specific services, and autonomy over the “delivery of skills” to clients would be controlled so that no other profession could infringe on the scope of practice.

An excellent example of this professionalization was the Flexner report of 1910, which was done to standardize medical education. This report resulted in the establishment of a single standard for medical education and found that the rigor for medical students was not sufficient to take care of the growing needs of communities and patients (Reeves, MacMillan, & Van Soeren, 2010). At the turn of the century, approximately 4% of women were graduating from medical schools, but shortly after the medical school overhaul resulting from the Flexner report, that number dropped to 2.9% (More, 1999). However, as the societal landscape of America was changing and healthcare reform needed to be identified, medicine and nursing education required a transformation (Matejski, 1981). Population growth and nationwide changes in the cultural landscape were creating challenges for healthcare (Beck, 2004). The Flexner report identified the need to care for communities, contain epidemics, and control chronic diseases in an increasingly interconnected world by collaborating between medicine and public health professions (Maeshiro et al., 2010). Flexner also expressed the need for physicians to focus on “social and preventative medicine” rather than “individual and curative medicine,” stressing the importance of having public health in clinical education and training (Maeshiro et al., 2010, p. 211). After the standardization of medical education was established by the Flexner overhaul, the numbers of women in medicine dropped further because of the competitive pool of applicants this shift created (Markowitz & Rosener, 1973), as well as the closure of medical schools devoted to women (Hiatt & Stockton, 2003). By limiting the number of medical schools and healthcare opportunities for women, competition increased and the pool of applicants consisted predominantly of upper-class White men. Formal training and gender privilege



gave men access to education that were denied women, and this reinforced the historic male dominance over healthcare (Hall, 2005). According to Witz (1990), physicians used education as a way to advance their own power and authority while keeping women out of medicine. By 1949, almost 40 years after the Flexner report, only 5% of women were physicians in American and that percentage would remain until the early 1970s (More, 1999).

In 1920, the Rockefeller Committee commissioned a report on public health nursing. The Study of Nursing and Nursing Education in the United States by Josephine Goldmark (also known as the Goldmark Report) would try to accomplish for nursing what the Flexner Report did for medicine, but it would not effect a comparable change (Gebbie, 2009). While the trend of moving patients from home care to hospital care increased, meeting patient needs created a strong demand for staff at the bedside. Schools of nursing were forced to accept students based on need rather than qualifications (Gebbie, 2009; Matejski, 1981). Many schools of nursing were identified as having substandard practices and, although the report generated information on the need for change in nursing education—specifically community health nursing and education, it lacked the same political and societal energy or interest as the Flexner Report (Matejski, 1981). Nursing schools across the country would not receive the type of surveillance or overhaul that medical schools had experienced, nor would they obtain large endowments to improve facilities and nursing education. Furthermore, nursing education would be managed by doctors as a way to control knowledge, curriculum, and scope of practice (Bell, Michalec, & Arenson, 2014). Doctors controlled what nurses were learning to “ensure medical education was more superior and prestigious” (p. 100). The division

between the professions was rigorously constructed along gender lines, ultimately feminizing other health professions that would be viewed as inferior to medicine (Reeves, MacMillan et al., 2010).

According to Turner (1995), the question of professional status for nurses has historically focused on the issue of gender. At the turn of the 20th century, there was a clear understanding by both the private and public sectors of the “sexual division of labor”: women were caretakers of their families and men worked outside the home (Bell et al., 2014, p. 99). Bell et al. further explained how medicine would use gender “as justification for and naturalization of medical hierarchy” and that nursing was a good “compromise occupation” for women; in fact, the “structure of the medical model was built upon the patriarchal model” (p. 99). Turner wrote that nurses were perceived as having a lack of commitment to their career because of their domestic obligations, which then justified women’s entry into the workforce and “naturalizing” their role as subordinate, like a wife to her husband. Much as the wife was considered to be the appendage of her husband, the nurse was seen in the same way for the doctor. The nurse was considered “worthy” only if she was helpful and followed the orders of the doctor (Keddy, Gillis, Jacobs, Burton, & Rodgers, 1986). This subordination to the medical profession and the social theory that nurses executed decisions on behalf of the doctors have remained critical barriers.

Medicine has also historically claimed “status” and professional jurisdiction over nursing and other “semiprofessionals” by subordination, limitation, and exclusion (Reeves, MacMillan et al., 2010). As Bell et al. (2014) noted, “Status essentially assigns worth to different categories of people based on shared cultural beliefs and stereotypes”

(p. 100). By having professional status and controlling the scope of practice, medicine has been able to monopolize treatment, narrow professional territory, and deny access to alternative and competitive practice (Turner, 1995). Medicine would be the first of the healthcare professions to professionalize, based on the Flexner Report, giving it prestige over all other healthcare occupations (Reeves, MacMillan et al., 2010). These boundaries and territories have been guarded to minimize other professions “infringing” on its area of expertise. Having power over other healthcare professions also gave doctors higher social status and prestige. According to Abbott (1981), status among professionals has a hierarchal order, and he defined “status systems” as being based on “honor, power, wealth, and knowledge” (p. 820). Abbott also explained the social order within the professions and how a certain level of “deference and precedence” during the interaction between professionals sets them apart in this hierarchy. These roles and relationships that have developed throughout history within the professions are strongly linked to societal stereotypes and gender assumptions. Behaviors are believed to be biologically determined, and gender determines ability and identity (Sweet & Norman, 1995). Men are the decision makers, women follow orders; doctors are dominant while nurses are subordinate and passive. These stereotypes are gender-based roles, creating the perception that medicine was a predominantly male profession and nursing was a predominantly female profession.

Medicine and nursing continued for decades to have a hierarchal division of control and professional boundaries and are part of the division of gender roles within the professions. A fundamental fact of professional life is interprofessional competition. According to Abbott (1988), “It is the history of this competition that is the real,

determining history of professions” (p. 98). In 1968, Leonard Stein wrote about the doctor-nurse game, in which he described the rules of the doctor-nurse relationship as being an “understanding” or “agreement” between the professions. The role of the doctor was described as superior to the nurse, and their interactions were explained as “carefully managed” and “designed to avoid confrontation” (Reeves, Nelson, & Zwarenstein, 2008, p. 1; Stein, 1967). Dorothy Rogers, RN, wrote about “teamwork” in her 1932 article “Teamwork Within the Hospital” when it came to the hospital “game” and the need for personal gain within the team; instead, she focused more on achieving professional acceptance. Some of these beliefs and misconceptions continue to exist today and account for the divide within interprofessional relationships and jurisdictions (Reeves, MacMillan et al., 2010). According to Reeves et al., when healthcare professionals understand each other’s roles, their relationships improve. For decades, healthcare leaders have been recommending team-based patient care, and research has proven that by breaking down barriers and preconceived notions and beliefs between disciplines, interprofessional relationships improve, as do patient care and outcomes. Instead, by controlling the scope of practice and restricting contributions interprofessionally, professions develop on the foundation of their separateness rather than their cohesiveness (Reeves, MacMillan et al., 2010). Thus, this division within the professions is one of the reasons that IPE is so crucial for patient care. During IPE, students learn to respect each other’s roles and contributions to the “team,” and the lines between professions are diminished depending on the needs of the patients, not the “status” or “gender” of the professional.

## **Divisions Through Role Development**

Although an IPE team consists of many members, such as physical therapists, occupational therapists, nutritionists, and social workers, the key players have long been identified as physicians and nurses. Much of the inequity within the team dynamics is related to professional hierarchy and gender roles. This inequity between medicine and nursing stems from the evolution of the professions. Abbott (1988) has argued that professions are “occupational groups” with specific skills and authority. As professions develop and become professionalized, they become more exclusionary rather than inclusionary because of the need for control and division of jurisdiction (p. 117). As roles became more defined and segregated, the desire for independence and autonomy starts to evolve and affect interprofessional relationships (Matejski, 1981, p. 18). The doctor-nurse relationship interprofessionally, as Turner (1995) has explained, has been affected by the historical patriarchal division within the professions, explaining that nurses merely executed the decisions made by doctors and have difficulty initiating professional autonomy. Turner noted that some literature has described doctors as having scientific knowledge and authority while nurses have practical jurisdiction. Nurses were known to perform physical actions that the doctors ordered, thus exemplifying the division between these two professions, much like the division within the family between husband and wife. Throughout history, healthcare has been plagued with a hierarchal division of power. Witz (1990) has argued that professions are linked with the idea of gender as well as power. This combination between gender and professional roles makes relationships difficult because of the involvement of occupational dominance and subordination. Historically, medicine, as a male-dominated profession, has been identified as having a

dominant role in healthcare, while nursing, as a female-dominated profession, has been identified as having the subordinate role within the interprofessional relationship (Manley, 1995). Now, however, although nursing is still a female-dominated profession with an interprofessional philosophy base, professional students of both genders are exposed to other roles in healthcare. This exposure can give these students a broader view of the different scopes of practice and help gain respect for other professions within the healthcare team.

### **Evolution of Interprofessional/Intraprofessional Teams and Challenges**

In 1972, the IOM's report, "Educating for the Health Team: Report of the Conference on the Interrelationships of Educational Programs for Health Professionals," identified the need to transform the healthcare delivery system and focus on interdisciplinary teams to meet the health needs of individuals and communities. The need to adapt to changes in healthcare was identified nearly a decade earlier. According to Lambertsen (1966), patients were becoming very knowledgeable about the type of healthcare they wanted to receive. With growing technology, changing patient populations, and demands for health services, healthcare professionals needed to provide the kind of care that both patients and communities expected. Patient relationships with doctors, nurses, and healthcare administration were now referred to as "teams" because of the necessity to manage individual patients, families, and communities more effectively. According to the IOM (1972), the "team" is a complex interaction between health professionals to deliver care that is derived from the patients' needs and is dedicated to their satisfaction and the fulfillment of those needs. This concept of "team" must be communicated to all students who are being educated in the healthcare professions by

those who are teaching in these institutions of learning. To this end, Stewart (1972) identified several inconsistencies between the educational programs in healthcare and the social environment of patient care. He identified that over the past 50 years, not much had changed in education, but there was a shift in the health goals of the public. Technology of medicine had advanced so enormously, causing detachment between professional theory and practice. It was understood that it would take more than one healthcare professional to manage the needs of individual patients and communities. The team approach to healthcare was determined to be the way.

One of the first documented studies on the team approach was presented in 1948 by Dr. Martin Cherkasky, who explained in a document entitled *The Montefiore Hospital Home Care Program* how patients needed a team approach to individualize their care for better outcomes. He recognized how hospitals and modern medicine had accomplished so much in terms of diagnostics and procedures, but had forgotten “the patient as social human being” and did not consider the whole situation of the individual patient (p. 163). In this document, he defined each of the “team’s” roles and how each would use its expertise to manage specific patient needs. Each team member, according to Cherkasky, would be placed in a leadership role, depending on the needs at the time, with each team member playing an intricate part in the patient’s care. His work with the Home Care Program has been recognized as a leader in the concept of healthcare teams (Baldwin, 2007). It has been thoroughly documented in the research for the benefits that teams provide for healthcare. Improved interprofessional work relationships, team work, job satisfaction, better understanding of everyone’s individual roles and scopes of practice, and communication have been directly linked with team training within healthcare

settings and education (Haynes & Strickler, 2014; Johanson, 2008; Schuetz, Mann, & Everett, 2010). Today, TeamSTEPPS, which is a systematic approach to incorporate teamwork into practice and hospital settings, has been directly correlated to improved interprofessional collaboration, communication, mutual respect, and patient safety and outcomes (Haynes & Strickler, 2014).

### **Evolution of Interprofessional Education (IPE)**

Throughout the history of healthcare, education reform has been identified as a way to manage the changes and needs of a challenged healthcare delivery system (Baldwin, 2007). Baldwin uncovered the origins of interprofessional teamwork and education in the United States. In the early 1970s, team-based approaches to primary healthcare were identified as ways of managing the complex needs of patients and communities. The interest in implementing interprofessional education launched the initiative to create new models of education in the United States (Blue, Brandt, & Schmitt, 2010). After the recommendations and support of the IOM for interdisciplinary education for health science students, federal funding became available to support many health science programs in implementing IPE in the curriculum (Baldwin, 2007). From the IOM (1972) report, an early definition of interdisciplinary education appeared: it was that an educational experience can be interdisciplinary at the level of students, at the level of faculty, or both. Thus, each of the following combinations can be considered interdisciplinary: (a) students from more than one health profession taught by faculty from one health profession; (b) students in one health profession taught by faculty from more than one profession; and (c) students from more than one health profession taught by faculty from more than one profession (Pellegrino, 1972).



As IPE began evolving in some universities and health profession programs throughout the 1970s, different approaches to the curriculum started taking shape. According to Baldwin (2007), interprofessional clinical experiences, community outreach programs, and summer and winter clinical programs were taking students out of the classroom and placing them in hospitals and communities to work together. However, by the late 1970s, much of the funding was gone for these programs and interest in continuing them declined because of the expense to organize and run these programs, in conjunction with the pressure within some programs from faculty to have more autonomy and professional identity.

Unfortunately, many IPE programs and team-based learning did not survive into the 1980s and research suffered as a result. However, those who did survive continued researching the need for learning together. The WHO in 1988 released the report “Learning Together to Work Together for Health,” which focused on “multiprofessional” education. An early definition from this report was as follows:

The process by which a group of students from the health-related occupations with different educational backgrounds learn together during certain period of their education, with interactions as an important goal, to collaborate in providing promotive, preventive, curative, rehabilitative and other health-related services.  
(p. 8)

In 2009, the WHO adopted and adapted a definition from the 2002 definition established by the Center for the Advancement of Interprofessional Education (CAIPE). As a result, the WHO’s definition now reads, “Interprofessional education occurs when learners from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (p. 2).

In 2011, the U.S. competencies (IECP Expert Panel), such as American Association of Colleges of Nursing (AACN), American Association of Colleges of Osteopathic Medicine (AACOM), American Association of Colleges of Pharmacy (AACP), American Dental Education Association (ADEA), Association of American Medical Colleges (AAMC), and Association of Schools of Public Health (ASPH), collaborated and identified these four domains of competency:

- Interprofessional Teamwork and Team-Based Practice,
- Interprofessional Communication Practices,
- Values/Ethics for Interprofessional Practice, and
- Roles and Responsibilities for Collaborative Practice.

Each discipline was intended to have “understanding and respect for the other members of the team, to be able to collaborate effectively for the patient with optimal results” (IPEC, 2011, p. 23). According to Speakman (2017), these competencies serve as a “framework to provide universal themes” that would support and guide collaborative practice as well as health professional programs seeking to implement this form of education (p. 12).

For nearly the last two decades, there has been a resurgence in IPE education and team-based healthcare. The latest IOM report, “Assessing Progress on the Institute of Medicine Report the Future of Nursing,” was released in December 2015. Interprofessional collaboration and the role of nursing leadership were highlighted and validated throughout, as exemplified by the following statement: “cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable” (p. 3). Notably, since the first report was released in 2010, “interprofessional programs

have expanded rapidly at schools of nursing” and evidence has indicated that “collaboration and mutual respect among health care professionals has been associated with improved patient outcomes, cost, saving, and increased job satisfaction” (p. 1).

### **Theoretical Context for the Phenomenon: Transition**

By definition, a transition is the process of a period of changing from one state of condition to another, such as when students are in a transition period to becoming a nurse and are transitioning or changing and transforming into their professional roles (*Merriam-Webster*, 2015). Transition into practice has been documented in the literature as far back as 90 years ago with the Goldmark Report, but it was not until 1974, with the work of Marlene Kramer who described transition as “reality shock,” that the theory of transition into practice was realized. Kramer’s theory described the obstacles nurses faced upon entering their first professional role. Similarly, Duchscher (2008) described “transition shock” as the “most immediate, acute, and dramatic stage in the process of professional role adaptation for the new graduate” (p. 1104). The literature on new graduate nurses and transition into practice has since become extensive, but little is understood about nurses who have graduated from having IPE experiences and what their transition is like. In addition, not much is understood about how novice nurses “survive” and “thrive” during the transition period. According to Chandler (2012), “it is not clear how the novice nurse survives the transition into practice, provides the best possible care for patients, builds on school knowledge, and, most importantly, learns to thrive during the first year” (p. 103). To this end, the IOM (2010) and the National Academies of Sciences, Engineering, and Medicine (2016) have recommended bridging the gap

between student and professional roles with suggestions of residency programs to allow for a seamless transition into practice.

The WHO (2010) expressed the need for practice-ready professionals; however, there is significant doubt about their readiness ability following graduation, given the high acuity level of patients. According to Spector et al. (2015), the complexity of transition into practice needs more attention than ever. With a growing diverse population, aging, comorbidities, and an alarming number of medical errors, transition into practice programs is critically needed. The IOM and the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) have suggested residency programs, but they are in the minority; by contrast, IPE experiences explore “practice” of real-world roles as team-based health professional students. In 2015, the National Advisory Council on Nurse Education and Practice (NACEP) suggested that students will need to learn the “value of teamwork” and health professionals will need ongoing training to “function within the team” for team-based care to succeed (p. 2). Learning how to function within a team needs to begin during the formative years of learning and be ongoing throughout the professional career.

### **Experiential Context**

My interest in the phenomenon of transition stems from my experience as a nurse who came from a collaborative unit and entered a new environment, not as a new nurse but as a nurse who transitioned from one culture to another. While I worked in labor and delivery (L&D) at Richmond University Medical Center (RUMC), I felt I was working to my full scope of practice. I was autonomous in my role and felt much supported by colleagues and administrators. The leaders of the unit were very proactive and engaged

the staff to be active participants in patient-centered care. I worked in this specific unit for almost 10 years and I believed I was a respected member of the team. Patient satisfaction and positive patient outcomes were part of the pride of this unit, and we were all equally part of its success. However, it was not until I left this hospital that I realized not all hospital units are as interprofessional as the one I left.

I began my transition as a per diem nurse in a new L&D unit. By contrast, the new environment I entered was neither collaborative nor “team-based.” As I recall, it was unsettling to feel like a novice again—I was transitioning again. Like the IPE new graduate nurse, I came from a culture of collaboration with a team-based philosophy, but this new environment did not parallel/perpetuate that culture and it was a shock to me. I was experiencing both transition shock as well as culture shock, even as an expert nurse. I found it very difficult to enculturate myself into this new environment and decided it was not the right fit for me. I resigned from this position a year and a half later, primarily because I did not see having a professional future there. I have since returned to my original hospital and enjoyed a short tenure in a per diem position in the Maternal Child Unit, but now have a full-time faculty role at a very collaborative university.

I believe one promotes or brings about change once one has lived through an experience and has time for reflection. While researching this phenomenon, I realized how much there is to learn about transitioning new graduates into their first role. Originally, I was interested in learning about communication. Why did there still seem to be a lack of communication in the profession? This search led me to the topics of collaboration and communication, but even that information did not satisfy my need to understand why communication continued to be lacking and how could it change. The

research led me more deeply into collaborative practice and team-based patient-centered care, followed by an exploration of interdisciplinary teams in healthcare. Once I started reading about interdisciplinary teams, IPE surfaced in the discussion and I found the root source of my investigation. If we could change the way healthcare professionals are educated, perhaps we can change patient satisfaction and outcomes. I wanted to discover where this type of education was actually happening effectively, and my search led me to Thomas Jefferson University in Philadelphia, Pennsylvania. There, I attended my first of many IPE conferences and learned that IPE was not exactly a new concept. In fact, it has been around for over 100 years.

With today's fast-paced healthcare changes, this study is an important opportunity to learn how IPE is meeting these shifts by developing healthcare professionals to be effective collaborators, communicators, and healthcare team members. I am passionate about the future of nursing, how nurses are educated, how to better educate my own students, and what the future of educating healthcare professionals should be.

### **Summary**

This chapter presented the evolution of the topic from a historical, theoretical, and experiential background. The history of how gender roles have played a significant part in the development of professionalization, as cited by Abbott (1988), may contribute to why the profession of nursing is still trying to validate its professional credibility today. The need for team-based patient care was explored, especially through the 1948 work of Dr. Martin Cherkasky and the Montefiore Hospital Home Care Project, which identified that the focus of care needed to return to the patients and each profession had unique

qualities to contribute to that care. This chapter also looked at the evolution of IPE as a model of education for all healthcare professionals which, although it historically lost some momentum, is having a resurgence of interest today. The knowledge learned from studying how graduates with IPE experience have transitioned into practice may be significant to the learning and understanding of transition for future nurses. Nursing administrators, educators, and healthcare professional program directors and deans may gain great insight from this study.

### Chapter III

## METHODOLOGY

A good phenomenological description is collected by lived experience and recollects lived experience—is validated by lived experience and it validates lived experience. (van Manen, 1990, p. 27)

Phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworld. (van Manen, 1990, p. 11)

### **Introduction to the Phenomenological Approach**

The aim of phenomenology is to gain insight into or understanding of the meaning of experiences that occur in everyday life. Phenomenology gets to the meaning of experience and uncovers what it was like for an individual. The essence of the phenomenon is to “uncover” and “describe” what is concealed within and reveal its meaning as the lived experience (van Manen, 1990). Phenomenology as a philosophical perspective and research method focuses on the human experience (Wojnar & Swanson, 2007). A phenomenological method of research assumes that there is some form or structure to the human experience and each human person experiences life differently (Thorne, Kirkham, & MacDonald-Emes, 1997); in short, any possible human experience is a phenomenon (van Manen, 1997).

Hermeneutic phenomenology is a human science that seeks to describe the experience, the essence, as described by those who have been through the experience, but



it also interprets the meanings of the lived experience (Dowling, 2007). According to Dowling, hermeneutic phenomenology and phenomenology depend on each other and, through reflection of the lived experience, the meanings are revealed. A researcher using this approach would listen to the description of the “reflective” narration and begin to interpret how its meanings relate to both the person and the meaning itself. Stories of the lived experience reveal the meaning, but to examine the meanings thoroughly, the story must be heard. Through an account of the experience, the story is revealed and the essence of the meaning is interpreted through text (Lindseth & Norberg, 2004).

The focus of all phenomenological research is the “attempt” to describe and understand phenomena (Wojnar & Swanson, 2007). For a nursing researcher, phenomenology is particularly useful and appropriate because it contributes to understanding a patient’s experiences and how nurses can apply the information to make a difference (Thorne et al., 1997). Nurses are taught to use critical thinking while caring for patients and develop instincts to assess and intervene when necessary. This intuitive nature merges well with hermeneutic phenomenology because nurses may have the skills to interpret meanings in the experiences that the subjects are describing.

### **Rationale for Choosing the Phenomenological Method of Inquiry**

When a researcher seeks to capture the essence of a lived experience, according to van Manen (1990), he or she must acknowledge that the “facts” of the lived experience are always already meaningfully (hermeneutically) experienced. Van Manen described hermeneutic phenomenology as being attentive to both descriptive and interpretive methodology. With descriptive (phenomenological) methodology, he suggested being

attentive to the appearance of things and allowing them to speak for themselves. With interpretive (hermeneutic) methodology, van Manen explained that there are no such things as uninterpreted phenomena. Capturing in language (the human text) the “facts” of lived experience is inevitably an interpretive process.

This study described and interpreted the meanings to a degree of the richness and depth shared by graduate nurses of their experiences of the phenomenon of transition into practice: specifically, nurses who have graduated from an IPE learning environment and now work in a clinical setting. Since the feeling of transition is a uniquely lived experience, the process of phenomenological reduction literally allowed the researcher to “reduce” the world to its pre-reflective state before there was a chance to understand or explain it (Dowling, 2007). According to Dowling, reduction is the key strategy of phenomenology which looks for the essence of the lived experience.

Phenomenological research is interested in what is “essentially” unique, not “replaceable” (van Manen, 1990, p. 7). Phenomenological research is particularly characterized by its interests in the lived experience of the world in its natural attitude. A phenomenological question seeks to reveal pre-reflected and pre-understood experiences. Van Manen’s phenomenological method guided this study because the phenomenon of transition into practice within the context of graduate nurses from an IPE learning environment has not been examined or considered before. Thus, this study sought to discover the essence of the lived experience to reach a better understanding of this learning model for nursing educators as well as new knowledge derived from the findings of this study for healthcare administrators.

Allowing nurses to become the authors of their own reality is the essence of phenomenology. “What first of all characterizes phenomenological research is that it always begins in the lifeworld” (van Manen, 1990, p. 7). Van Manen elaborated that it is in the true “attitude” when we are reflective that we become more aware of the experiences we live. Through an interpretive phenomenological method based on Merleau-Ponty’s (1962) philosophy and van Manen’s (1990) phenomenological method, this research examined the central focus of the experience of transition into the professional role. When we share our experiences, we offer meaning to our world. The essence of the narratives brings us more in touch with their lived meanings (Munhall, 2012). Phenomenology offers a good fit to nursing philosophy and nursing art because it takes into consideration the individuals’ interactions and meanings of the environment (Lopez & Willis, 2004). Nursing research strives to develop knowledge that is relevant to patient care. The value of these experiences will not only advance understanding beyond the known, but also how they capture the experience of the lived.

Phenomenology looks for meanings in the experiences and their significance. It teaches us that we have pre-understanding and are not looking for questions to solve (van Manen, 1990). Because each person’s experience is unique to that individual, finding similarities in a specific inquiry can only enhance the understanding of that particular situation, but does not claim to understand every situation. Van Manen explained that phenomenology questions “what is the nature of meaning of something” (p. 84) and so we must re-learn the meaning as we experience it. Studying the lived experience of transitioning into practice after experiencing IPE will enhance understanding for educators of IPE, traditional nursing, and healthcare professional programs, as well as

provide insight for administrators of hospitals and healthcare facilities to bridge a seamless transition to practice more effectively.

### **Background of Phenomenology**

Edmund Husserl (1859-1938), originally a mathematician, is considered to be the founder of phenomenology as a philosopher. Husserl (1970) defined phenomenology as a discipline, a science of the human consciousness. The Husserlian approach sought to discover the meaning of the lived experience through listening, interaction, and observation (Husserl, 1970). The transcendental experience, then, is when the researcher is able to abandon his or her own reality and preconceived notions and describe the phenomenon in its purest form (Wojnar & Swanson, 2007). This process is known as “bracketing,” which can be described as separating the phenomenon, defining and analyzing it, and suspending any preconceived assumptions about the phenomenon while interacting with the participants of the study. The purpose of using bracketing is to “bracket out” and acknowledge any beliefs or perceptions about the phenomenon in order to limit any personal bias by the researcher.

Merleau-Ponty (1908-1961) was a French philosopher and one successor of Husserlian phenomenology. The aim of Merleau-Ponty’s phenomenology is seeing the world as we meet it in our immediate experience and giving a direct description of that experience (van Manen, 1997, 2014). Merleau-Ponty believed that the only way to understand a phenomenon was to return to the experience of that phenomenon. In other words, it is only through the experience that anyone can find the essence of life and, in turn, through perception and awareness, meaning is found. Merleau-Ponty’s (1945/1962)

belief was that the purpose of phenomenology was to find meaning or essence (true meaning of something). His interest was to understand how a person's experience in an ordinary day could impact and reflect on his or her world. The world is not what one thinks, but that which one lives (van Manen, 1997).

The goal of Merleau-Ponty's phenomenology of perception was to rediscover first experiences and this can be accomplished by the use of reduction to reach this original awareness (Dowling, 2007). Reduction allows us to discover and awaken with the "amazement" and "wonder" of the lifeworld (van Manen, 1990). According to Merleau-Ponty (1962), it is likely that we will forget the world at the time of the experience and we need to gain insight into the perceived world. Through rediscovery of the perceived world, we can gain insight into and find meaning in life. Furthermore, Merleau-Ponty explained that when we return to the lived experience, its essence is emphasized and the true meaning of the lived experience is clear. The idea that our perceptions of the world and our lived experiences are how we come to human understanding is at the core of Merleau-Ponty's phenomenology.

Fundamental to Merleau-Ponty's (1945/1962) philosophy is understanding the difference between the researcher's interaction with the participant and the interpretation of the phenomenon that the participant is describing. Thus, the interaction and the interpretation create an understanding of the phenomenon together. The hermeneutic approach of reflection on the everyday lived experience constitutes the phenomenological question in which Merleau-Ponty believed. Hermeneutic phenomenology believes that researcher and participants come together and, through the process of interaction and interpretation, a phenomenon is studied (Wojnar & Swanson, 2007).

Merleau-Ponty provided a foundation for van Manen's (1990) methodical themes of human science research, which is the method that guided this study. The phenomenologist, as a human science researcher, can write down the descriptions of the life experience and allow the essence of the meanings to resonate. According to van Manen (1990), becoming sensitive to human phenomena and not to a set of "predetermined" recipes, in order to arrive at a scientific result, is how we can discover the meaning of the human experience. I employed van Manen's general procedures for carrying out this phenomenological study.

Van Manen's (1990) themes of human science research are a phenomenological method involving the following six research activities:

1. turning to a phenomenon that seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes that characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon;
- and
6. balancing the research context by considering parts and whole.

According to van Manen (1990), the first activity—turning to the phenomenon of the lived experience—is driven by the commitment to a thought or an inquiry. It is the kind of thinking that guides us from the abstract to the reality of the lived experience. A phenomenological method of inquiry is an effective way to examine transition as it is

experienced. According to van Manen, “from the phenomenological point of view, to do research is always to question the way we experience the world” (p. 5).

The second activity is the investigation process. This occurs as we ask and collect lived experience data to provide a description about a phenomenon that the researcher wants to understand. During this process, bracketing of personal beliefs and opinions is used to avoid interpreting the phenomenon. According to van Manen, the problem with phenomenological inquiry is not that the researcher knows too little, but that he or she knows too much about the phenomenon. Thus, by using bracketing, the researcher “suspends” his or her biases to study the essence of the natural world. For the nurse who has transitioned into practice after graduating from an IPE environment, the interviewing process will allow her to reflect back on what she experienced.

The third activity—reflection on the essential themes that distinguishes the phenomenon—requires thoughtful reflection on the part of the researcher. The researcher looks for the significance about the lived experience described by the participants. Through “true reflection,” the researcher can grasp the “special significance” of the experience and not focus on what it looks like, but on what it is like (van Manen, 1990, p. 32). It was this researcher’s intent to identify themes and meaning associated with the lived experience of graduate nurses transitioning into practice.

The fourth activity—describing the phenomenon through writing and rewriting—is the application of language and thoughtfulness that helps to reveal the phenomenon in question. The written word, the text, and what the interpretation reveals have more to do with the phenomenon. The participants engage in descriptions of their personal experiences, and giving text to these themes through reflective writing leads to an

interpretation of the intensity of the meaning. Through this immersion, it was the intent of this researcher to describe the meaning of transition into practice.

The fifth activity is maintaining a strong and oriented relation to the fundamental question and to the phenomenon. It is important to remain on course and not become distracted by maintaining a strong relation and commitment to the question. According to van Manen (1990), to do phenomenological research, one must be strong in his or her position and not accept untruthfulness or falsities instead of the true experience of the participants. By maintaining commitment to the phenomenon, identifying themes, and deriving essences from the reflective writings, it was possible to examine and document transition into practice.

The sixth and final activity is balancing the research context by considering the parts in significant association to the whole. During this step, the researcher needs to be consistent in reflecting back and reviewing the study, and looking for the significance that each part of the experience contributes to the whole. Through deliberate thought and writing, the present researcher intended to accomplish a meaningful understanding of the experience of transition into practice.

Although van Manen (1990) explained these six steps or research activities as a general procedure for phenomenology, he did not see them as rules; instead, they provided an outline for a researcher to follow as he or she worked through the process.

### **Summary**

This chapter reviewed the origins of phenomenology, ranging from the German scholar Husserl and the French scholar Merleau-Ponty to the Canadian scholar van



Manen. It also explored the parallel ideas of Merleau-Ponty, who believed that meaning comes from our perception of the lived experience, and van Manen, who sought to uncover and describe the lifeworld as it is experienced using an individual's description as well as an interpretation of the interview data. Finally, van Manen's method was explored in detail according to six steps or research activities that serve as an outline for researchers, which provided a rationale for why this philosophical approach of phenomenological research was chosen as the guiding method for this study. Chapter IV next presents van Manen's phenomenological method as it was applied to this research study.

## Chapter IV

### METHOD APPLIED

#### **van Manen's Method of Phenomenology**

This chapter explains how the selected method of research was applied to and used in this phenomenological study. Van Manen's (1990, 1997, 2014) phenomenological method was useful in answering the overall research question, "What was the experience of transition like, having graduated from an interprofessional education (IPE) learning environment?"

#### **Participant Selection**

Recruitment of participants began with snowball sampling. When using qualitative and descriptive research methodology, snowball sampling is helpful for finding those participants who are difficult to reach or few in number (Baltar & Brunet, 2011). With snowball sampling, the participants are "seeds" that help to expand the subject group by recruiting others for the study (Heckathorn, 2011). Some other advantages of snowball sampling include its usefulness in gaining access to expand the sample size and scope of the study as well as in reducing cost, being practical, and increasing time efficiency. In addition, when a participant refers another individual to the study, there is a likelihood that a trusting relationship may develop. Some weaknesses of

this method may be tied to geographical scope and the time necessary to build trust between researcher and individuals as well as creating a subject pool and adequate sample size (Baltar & Brunet, 2011), which is minimal for the phenomenological method.

The first participant for my study was selected through a personal contact acquired during the proposal phase of my doctoral coursework. Prior to the start of writing the proposal, I met with an educator who introduced me to the interprofessional learning environment. I attended several conferences with her to understand the educational philosophy of IPE. She in turn provided several contacts who had graduated from IPE and initiated the snowball sampling. Once approved by the IRB, I began the process of reaching out to my contact person via email and extended the study's contact information to her. I designed business cards with my name and contact information for the primary contact and other participants to distribute so that potential participants could contact me, responding only if they were interested.

Participants for the study must be practicing female nurses who graduated from a 4-year baccalaureate degree program within an IPE learning environment. Participants must be working in a hospital setting and have transitioned into their professional roles. Through the snowball technique, I acquired a sample of 10 nurses who were graduates of programs steeped in IPE. The sample size was determined by a saturation of data, meaning that once repetitions in themes and information occurred, data collection was considered complete. I interviewed one additional participant to further validate saturation. Demographic information (see Appendix A) was collected from these participants.

### **Setting**

Once a participant agreed to be interviewed, she determined a mutually convenient private setting, preferably a local library, an available quiet room or conference room at the hospital where they work, or their home. Although the aim was face-to-face interviews, participant distance from the New York metropolitan area required the use of phone recording, FaceTime, or Skype for all participants.

### **Protection of Human Subjects**

Approval by the Institutional Review Board (IRB) of Teachers College, Columbia University was obtained to provide protection of human subject participants. Prior to the start of each interview, participants read the consent form. In addition, participants were provided a verbal explanation of the purpose of the study, the procedure, risks and benefits, and the assurance of confidentiality and anonymity. The participants were also advised of their rights as volunteers in the study as well as their right to withdraw from the study at any time without penalty. Each participant was given ample time to ask questions, and each participant signed a consent form. The participants were also informed of how the interviews would be obtained and stored and they agreed to be tape recorded (as explained on the consent form).

There was minimal risk associated with this study. Some risks anticipated included any distress that may be caused by reflecting on the past undergraduate experience or transition into their professional role. Each interview was audiotaped, encrypted, and sent via email to a transcription center where all transcribers have CITI approval. The transcripts were returned by email, also using the same encryption.

### **Data Collection Procedure**

Data collection involved prescheduled 60-90 minute interviews. To communicate during this study, a separate cell phone number and email address were used. Each participant contacted me to schedule each interview. At that time, we determined the best date, time, and location for a face-to-face interview (or any necessary alternative as Skype, phone, etc.). Participants contacted me through email, text, or phone; all of this information was printed on my business cards which I distributed. I reviewed the informed consent (see Appendix B) with each participant prior to the interview date via phone call or Skype/FaceTime to ensure her understanding of details. Given the distance with some participants, I reviewed the consent forms with each participant, which they all signed and transmitted back to me by fax or email prior to the interview.

Data collection involved prescheduled 60-90 minute interviews. Once the interviews were transcribed, the transcripts were sent to each participant for an accuracy check. During the phenomenological reflection process, participants were asked to review their transcripts for a future second interview in which they would be asked if they would like to expand on, clarify, or delete any parts of the interview.

Each participant completed a brief demographic questionnaire (see Appendix C) via email or fax prior to the interview. Demographic information was used to describe the study participants and determine study eligibility. It also included information on age, name of IPE program they attended, year of graduation, area of nursing where they started their transition, and name of disciplines with which they studied and participated in clinical learning experiences, including simulation laboratory and patient clinical settings. This demographic questionnaire took between 10 and 15 minutes to complete.

Each interview began with the question: “Tell me what it was like for you to graduate and then work as a graduate nurse in a clinical setting.” According to van Manen (1990), “The art of the researcher in the hermeneutic interview is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and the interviewee oriented to the substance of the thing being questioned” (p. 98). I allowed the nurse participant to elaborate on her experience at length before I reflected on some of her statements for clarification. I took notes throughout the interviews and reflected back in the journal to make sure I understood by asking an open-ended question. For example, when a nurse participant described a feeling such as feeling empowered, I would follow up with a question such as “Can you recall a particular moment or situation when you felt empowered?” Many of the nurse participants shared in-depth stories of their experiences with details of actual interactions with other healthcare members and patients, and I felt humbled by their willingness to be so open and generous with their stories. Before each interview was concluded, I offered each participant a moment to reflect on the interview and to provide any feeling or emotion that may not have come through during the conversation. Some participants were still interested in engaging in storytelling, while others had exhausted their thoughts and stories. At the end of the interview, a thoughtful “thank you” was shared, and I requested that each participant contact me if she had any thoughts or stories she felt she still needed to share. None of the participants have contacted me since their interview, but most wanted to receive a copy of the study when it becomes available.

Once each interview was transcribed, I listened to the recordings, following the transcript for accuracy and for first steps of data analysis. During this time, I also

reviewed my journal notes taken during the interviews to refresh my memory of the interview. Reflecting on the interviews allowed me to immerse myself in the study and the respondents' thinking. As van Manen (1990) explained, through reflection, "insights [are] gained, for discerning patterns of the work in progress, for reflecting on previous reflections, for making the activities of research are themselves topics for the study" (p. 73).

After listening to the recordings and reading the transcripts, I sent each transcript to each participant for any revisions or clarifications. During the follow-up process, I asked, "Does this reflect what your experience was like?" (van Manen, 1990, p. 99). According to van Manen, "The art of the researcher in the hermeneutic interview is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and the interviewee oriented to the substance of the thing being questioned" (p. 98).

### **Confidentiality and Data Storage**

To maintain confidentiality, I locked and stored all audiotapes in a metal cabinet in my home to protect each participant's privacy and confidentiality. Each document signed by participants, including consent forms and demographic information, along with audiotapes, transcripts, journal logs, and written notes, were stored there as well. Upon completion of the study, all study materials will be kept in a locked and secured location. As per research policy, these documents will be shredded after 5 years.

## **Data Analysis**

In phenomenology, the purpose is to capture the “essential meaning” of the lived experience (van Manen, 1990, p. 77). Van Manen explained that “The insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience” (p. 77). Themes applied may help the researcher when thinking of the phenomenon and developing ideas because meaning is difficult to reduce to one meaning. Themes became evident with each reading and rereading of an interview and were placed into categories to reflect their similarities.

Phenomenology seeks to capture that pre-reflective experience, and themes give “control and order to our research and writing” (van Manen, 1990, p. 79). Nurses who are ready to transition into their professional role after graduating from an IPE experience may know that their experience was different from the experiences of other nurses who did not transition from an IPE learning environment, but they may not know how to identify that time and the meaning of that experience. While conducting interviews, I was able to immerse myself in their stories to better understand their experience and attempt to identify repeated themes in order to gain insight into what the experience was like to transition into professional practice after receiving an IPE.

Data analysis continued through this immersion process. By reading and rereading the data (the participants’ narratives) and listening to the audiotape recordings of the interviews, I saw that the nature of the phenomenon emerged as themes and similarities became evident. I read my field notes and post-interview journals to review any nonverbal communication that may have been relevant during the interviews. In the



margins were notes to elicit a memory of the interview, and with highlighters I color-coded resounding themes that repeated themselves in each transcript. Interpreting the written text and analyzing the data “[mean] entering hermeneutical circle” (Lindseth & Norberg, 2004, p. 149). It is not enough to read several times to extract the meaning; we must be open enough to be “touched” and “moved” by the text that is speaking to us. The themes repeated themselves and offered a greater understanding of the nurses’ experiences.

In phenomenological research, the goal is to identify and blend the participants’ meaning and the researcher’s understanding to reach the essence of the phenomenon (Wojnar & Swanson, 2007). I used the methods of epoche and reduction to find the meaning of the experience. Epoche-reduction identifies genuine openness within the conversation about the phenomenon (van Manen, 2014). In my research situation, the nurse participants were aware that I had gone to conferences, learned about IPE during the beginning phases of my research, and had a clear understanding of what IPE was all about. I believe that this allowed the participants to open up about their experiences because they knew I had a general understanding of the type of education they had received. For researchers to use epoche, they must “bracket” any preconceived assumptions about the phenomenon being studied and put it aside to suspend any beliefs. Since this is not realistic, three processes were incorporated into the study. Assumptions and biases indicated my thoughts about findings. Experiential context revealed preconceived ideas. Epoche in my situation meant that I validated my understanding of the nurses’ experience with a nod or gesture, but I did not resort to my own experience or

understanding of IPE. I kept a journal to record thoughts, feelings, and issues that arose after each interview.

In phenomenological research, reduction means reducing the data to the closest essence of the experience and going back to the phenomenon. As van Manen (2014) explained:

Phenomenological reflection on lived experience is neither inductive nor deductive, rather it is reductive. Phenomenology does not try to develop conceptual schemes or prove a preconceived idea. Rather, the attitude of the Epoche-reduction tries to make contact with the experience as we live it. (p. 222)

### **Summary**

This chapter reviewed the methodology and rationale for using a phenomenological research for the study. The procedure, recruitment, data collection, data analysis, informed consent, and confidentiality methods were presented. Finally, the importance of epoche and reduction in the phenomenological research process was explained.

## Chapter V

### FINDINGS OF THE STUDY

In this study, the phenomenon of nurses' transition into practice after receiving interprofessional education was explored, described and illuminated. Ten female nurses were interviewed about their experience of transitioning into their professional roles. Van Manen's (1990) hermeneutic phenomenological method was used to describe, interpret, and analyze these lived experiences in an attempt to bring meaning or themes into textual form. According to van Manen (1997), an experience is not something like an object or a thing that can be generalized or described completely, because no two people have an experience in the same way. There is no formula to explain or describe completely the lived experience of a nurse who has transitioned into practice, but my attempt was to provide themes to the reader so that the experience may be understood.

#### **Participants' Demographics**

According to van Manen (1990), descriptions of the backgrounds of each participant are helpful in understanding the experiences and where they came from. By describing these nurses, the reader is able to imagine the person, who she is, and why she is part of the study. All the nurses in this study were incredibly enthusiastic about contributing their time and story as well as passing on their interest to others to enrich

this study. Van Manen (1997) described the interviewee in a hermeneutic interview as a co-investigator of the study, one who does not just have a passing interest but invests in the research. The nurses in this study were greatly interested and expressed a joint commitment to the process as well as the necessity of nursing research.

Each nurse shared her sense of her experience going from a student nurse, newly graduated, and transitioning into that professional environment and role. Depending on the hospital or home-health environment into which these nurses transitioned, each nurse talked about an orientation period. Nursing orientation begins once the new graduate is hired and often includes a period with a preceptor who is an experienced nurse in the assigned clinical area. In the interviews, each nurse reported taking a medication math test as well as a customer service test to ensure the new nurse understood basic “customer care” guidelines when managing patient care. Two nurses had a 3-month orientation period; four had a nurse residency position lasting 1 year. Three nurses were in a new-grad internship program during their orientation, which meant they had orientation for 6 months to 1 year and during the course of the program would be in interprofessional groups each month, learning how to work in an interprofessional environment. One nurse had a nurse leadership orientation for home-health nursing which lasted 3 months. Despite variations in the orientation periods as well as types of orientation, all of the nurse participants shared similar experiences during the orientation phase. See Table 1 for the participants’ demographic information. Note that pseudonyms, not actual names, have been used to identify the participants.

Table 1

*Demographic Information*

Name	Age	Year Graduated	IPE Cohorts	Current Position	First Position
#1 Christine	28	2015	Medicine OT PT Pharm Couples and Family Therapy	Neurovascular Surgery	Yes
#2 Joan	22	2016	Medicine OT PT Pharm Dietitian Social Work Psych Law	Emergency Room	Yes
#3 Amanda	25	2013	OT PT Dietitian Speech Pathology	Stroke/Surgery  Medical Trauma ICU	No  Yes  Same institution
#4 Lydia	22	2016	Medicine OT PT Anesthesia Medical Imagery Advanced Practice RNs	Clinical Pediatric	yes
#5 Annabelle	31	2015	Medicine Pharm	Telemetry Endoscopy	No Yes Same institution
#6 Karen	22	2016	PT Pharm	Oncology	Yes
#7 Heather	26	2015	Medicine Pharm Physician Assistant Dentistry	Cardiac ICU	Yes
#8 Roseann	34	2015	Medicine Pharm Dentistry	Hospice Case Manager	Yes
#9 Amelia	41	2015	Medicine OT PT Pharm Speech Pathology	Pediatric ICU	Yes
#10 Julia	27	2014	PT Pharm Radiology Respiratory Therapy	Medical- Surgical	Yes

## Individual Participants' Experiences

### Christine

Christine was very eager to be part of the interview process for this study. She expressed how research was very important to her and she was particularly excited to be a part of this study because of her IPE experience. Christine's name and contact information were given to me by a nurse mentor who has worked in the interprofessional arena for many years and taught Christine. She extended Christine's contact information to me to begin the interview and snowball process. Christine currently lives in the Northeast and is a neurovascular nurse in a major medical hospital there. She has been a nurse there for almost 2 years and felt she was able to transition "easier" than those nurses she started her internship with because her education focused on interprofessional collaboration.

We scheduled a FaceTime interview on a Sunday morning. Christine was dressed comfortably in sweat pants and a T-shirt, relaxed in her bed with a cup of coffee. She had her dark hair high up in a bun and, although a little tired, she was geared up for our FaceTime interview. After asking my initial question (What was it like to transition into your professional role?) and asking her to share her experience as a new graduate nurse transitioning, she began with the following:

I started working as; they call it a perioperative nurse intern, so it's kind of like a residency program but it's open to new graduates and experienced nurses who are just new to the operating world. And I started with a class of about sixteen nurse, fourteen of whom were new nursing graduates, and none of them had had the same experience I had during their undergraduate curriculum with interprofessional education. . . . But I thought it was a lot easier for me to transition to that role because even though I wasn't specifically aware of each of the roles that professions specific to the OR played, I felt more comfortable learning—or I knew how to learn about their roles and how to communicate in a

way that a lot of the other new graduates weren't comfortable doing. And I was very interested in learning about the other roles of the professions in the operating room.

### **Joan**

Joan was an upbeat, young new nurse full of excitement about her experience as an emergency room nurse. I received Joan's contact information through my IPE connection, contacted her, and received an immediate response to be part of the study. She presented as energized and was in athletic clothes, admitting she had come from exercising that morning ready for our FaceTime interview. Joan lives in the Midwest and is currently working in a major medical facility. She explained how the environment in the emergency room is "very fast-paced" and one needs to be able to communicate with the physicians who have probably not seen the patient yet and are "relying on you and your judgment to tell them what the patient needs." Joan also expressed how it can be intimidating at first to approach a physician who has 25 years of experience and how her IPE experience made it easier for her to talk to other professions by "knowing what their practice is, what their scope is, and how they can assist me in my own job and in taking care of patients." Joan told me a story about how her IPE experience helped her right after her orientation period:

I think the biggest part of my job, since everything is so time sensitive, is how to communicate effectively. . . . I had one time where I was on my own, it was after orientation, and I was very concerned about this patient who didn't look good in my opinion, but I had done my background research, I had done my assessment of him, and so I had something to back up my fears and have her [the doctor] go lay eyes on her, on the patient for me. And I was right, she needed to go straight to the ICU, so the patient was really sick. My suspicions were confirmed in that I was able to kind of overstep my fear of going directly to the physician with a fear but I was able to do that assessment and use those communication skills I learned in IPE to be able to do that. It felt great, it was

really satisfying. Yeah, it was really good. I think it develops a really good relationship too with your provider. I think it builds trust.

### **Amanda**

Amanda was a vibrant young nurse, very excited and enthusiastic about talking about her transition experience and nurse residency program after her IPE. She had long blonde hair pulled back into a ponytail and presented in a comfy, oversized sweater as we did our FaceTime interview. Amanda lives in the Midwest and works in the Medical Trauma ICU, her second position as a nurse in the same institution. What was interesting with Amanda's story was that she had not learned with medical students. She said "medical students were not required to take IPE like all the health science students were. And I just found that bizarre, considering that nurses collaborate the most with physicians." Amanda recalled a time during her own education when she felt IPE was "silly" to realize eventually how beneficial it was to her transition and practice; she shared, "I saw how much you truly do collaborate with all these interdisciplinary teams." Also interesting was Amanda's initial lack of confidence in the particular discipline during her transition that she did not receive IPE; as she expressed:

There's just been times, and especially as a new graduate, you're intimidated by attending physicians and, or even residents, and think if residents had a better idea of what nurses did, then maybe our opinion would matter a little bit more, especially when you're just discussing maybe a social work issue or a, you know, a psychological issue with the patient instead of just a biological problem. I mean, I'm not generalizing, that every physician has poor communication, but there definitely are some that just didn't really understand the little day-to-day things that a nurse does, and it would be a little bit frustrating if they didn't value your opinion.



## Lydia

Lydia was a pleasure to interview because her enthusiasm and excitement about the profession and being a nurse were infectious. She was dynamic and rich with information and ideas of her future in the profession. I received her contact information from a colleague of mine, and Lydia was eager to be part of this study. She presented in a comfortable-looking sweatshirt, curly brown hair, and glasses, and was prompt for our FaceTime interview. She is currently living in the Northeast and working on a Pediatric Oncology Unit which I related to for personal reasons—she was impressive.

Lydia took a travel nurse position because she felt it could help her to “well round” her experience and give her the opportunity to figure out where she wanted to settle. Lydia was so proud of her IPE experience, explaining that although it was a “scary transition to be in the new role,” she felt very prepared because of her education and “it eased my transition period.” Lydia expressed having confidence and found herself reflecting on her clinical experience and skills lab setting as well as going through scenarios in her mind during her transition phase. She explained that those moments “remained really prominent in the forefront of my mind while I was orienting on the new unit, putting the puzzle pieces together”; as a result, she felt very well prepared for her new role. Lydia explained a time she needed to advocate for a patient and “step on the toes by kind of bypassing a resident” when her assessment was questioned:

I’m thinking about a specific situation in my head right now, where I was very concerned about this small child whose parents didn’t speak English, and I was very concerned about his change in clinical status, and the resident wasn’t very concerned about it at all and, because he [patient] had been up and down, so it wasn’t a change in a sense, but it was a change I was uncomfortable with. I couldn’t leave the room. I called to have the fellow in; I presented what was going on in an SBAR format. The resident came in shortly thereafter and it was awkward because I had called in the fellow and he—you could see the tension

between the resident and the fellow because the fellow was very concerned with what he was seeing with the child. So I had to be the advocate. So like I said, despite the awkward nature of the interaction between me and the resident and the fellow, I just didn't feel comfortable with what was going on and moved up the chain of command.

When asked how that made her feel, Lydia said, "It made me feel awkward, but it was also empowering."

### **Annabelle**

Annabelle had such a compassionate and caring spirit about her. I received her contact information through an IPE contact from my IPE mentor. Annabelle presented with a short bob haircut, brown and neat, and wore rectangular glasses and a long-sleeve shirt. She appeared happy to participate in our FaceTime interview. She currently lives in the Northeast and works on a Medical-Surgical Unit.

During our interview, she expressed how organized she was and wanted to make sure that all her patients received proper care. Annabelle explained, "My first day off of orientation, you're like the coordinator of all things that happen throughout the day and for your patient, finding resources and trying to coordinate the day, it all got done through collaboration." She collaborated with the other team members to implement her care once she started working. During her IPE experience, however, Annabelle only learned with pharmacy students and medical students so she was exposed to what their scopes of practice were. Once she began working on her unit, she quickly learned who the PTs and OTs were and how to manage care with those resources in mind. Annabelle is the first nurse in her family and explained that she did not know one nurse personally before she became one, but she knew the type of nurse she wanted to be. When I asked Annabelle how it felt to be the nurse she wanted to be, she expressed:

I would say empowering, knowing that I had vital information that not everyone knew. The word comes to mind is like, like an orchestra director. I felt like that was always my role of just trying to figure out the plan for the day for the patient and then now always figuring it out and coordinating with all the different disciplines for that day, but also like making sure to communicate to the patient um and making sure that they were aware and if they had any questions, you know, in order for the day to go smoothly. . . . I felt like I was like the director of the day, like I'm a traffic controller of, of what everything was going on, but also like, you know, the—someone communicating to a patient that “This is what’s gonna happen for your day.” I always made sure to let them know what the plan was.

## **Karen**

Karen was a bubbly and enthusiastic new nurse who was currently in a new-grad program internship at a major medical facility in the Midwest. I received Karen’s contact information from a previous participant. Immediately upon interviewing Karen, I realized she had not had the same type of IPE that the others experienced. Moreover, although each of the participants came from various schools offering IPE, there were clear signs Karen had not received the equivalent exposure as those I interviewed before her. She was approximately 9 months into the orientation of her 1-year internship program and was extremely energetic. Karen was currently working on an Oncology Unit and described how much she was learning in the new-grad program about interprofessional and interdisciplinary collaboration. She went to a university that applied IPE experiences with physical therapy and pharmacy students in simulation scenarios and health fairs. What is the most interesting part of Karen’s history is that, even with her limited exposure to IPE during her undergrad, she was able to apply what she learned to the new-grad program, which is strongly centered on interdisciplinary collaboration. This major hospital is committed to enriching a collaborative team environment. Therefore, when asked about her transition into practice, this was Karen’s response:

It was a good transition. University has a lot of support, so I had multiple mentors. . . . I felt really supported, I felt like I could ask them anything. . . . We have monthly meetings and interdisciplinary training. We do interdisciplinary meetings with the M.D.s and the residents. One of the main residents talked to us just to explain what residents' day looks like, so that we kind of knew when it's okay to page, what they do. . . . There are group projects, so many classes and many different professional cohorts are there, not only nurses, we all learn together. I don't need to know everything and I can ask for help. I knew a lot more about PT and Pharm from school, so I felt very comfortable to approach them from the start and I think they trusted me. It felt really amazing to know I was doing something right and was trusted, they relied on me.

## **Heather**

Heather had the most calming presence. She had a big mane of dark brown hair pulled back into a ponytail with oval-shaped glasses, and she admitted to being a very introverted person. I had a very peaceful feeling as we proceeded through our FaceTime interview. I received her contact information from a previous participant who graduated with her. Heather was currently living in the Midwest and has been working in the Cardiac ICU for approximately 2 years. She had a very rich IPE experience during her undergraduate education and expressed right away that she was "definitely prepared for the transition," stating "they are trying to decrease the level of hierarchy and increase the scope of practice awareness"; teamwork and support were evident throughout the interview. Heather was also fortunate to enter a new-grad internship program which well-rounded her overall experience. When asked about her transition into her new professional role, she expressed:

I've learned a lot about teamwork, working in a team, and that's my favorite. I think it's great when you have a team that you are excited to work with. I'll get four nurses, PTs, and Respiratory Therapists in the room just to stand my patient up who's vented or whatever it may be, or get that patient up who is cannulated for Ecmo, we do progress mobility, we can do it. And just having that teamwork, knowing they got your back and you have theirs, makes you happy to go to work every day. It kind of feels like we are cheerleaders, like cheering each other,

rooting for each other, supporting each other. It's just a good feeling, I mean to have that kind of support, it's just knowing you're not alone and knowing someone has your back.

### **Roseann**

Roseann was the only nurse who was not at the bedside in a traditional role. I received her contact information from a contact through my IPE mentor. Interviewing Roseann was a humbling experience because of the way she gives herself in her role to the team and, most importantly, to her patients. Roseann had brown curly hair in a bob-style coif and black-rimmed glasses. She wore a crisp white button-down shirt and sat at attention while I interviewed her on FaceTime. Roseann presented as a mild-mannered person who spoke softly and kindly, and I realized right away that she had been guided to the perfect role. When I interviewed Roseann, she was a hospital hospice case manager. Upon graduation from her BSN program, Roseann found herself in the position of accepting the offer to be a hospice case manager. She reported what it was like to be in the field and being the “coordinator of the team”; she also noted how her IPE was the most important training in nursing school for her position. I felt immediately fond of her and connected with her compassionate personality. Roseann explained how rewarding her job was and described it as much more than she could have imagined it to be—it was “just beautiful.” When I asked her what it was like for her to transition into her professional role, she described how she realized she possessed skills that many of her fellow nurses with decades of experience did not.

I think in the past nursing education, training, was much more task-focused and more in an accessory role to the physician. Whereas I think my training and education was much more focused on autonomy with a team approach and what can nurses do? What is the nurses' work that no one else can do, our roles, and how can we be leaders? I think that really prepared me, also, just feeling

comfortable being an equal player with the physicians. I think I was really taught that nurses bring just as much to the table as physicians and that there are other roles in the team. So that really helped me, that training and that perspective to feel like an equal member. There's also a lot of advocacy that we have to do as hospice nurses to get our patients' needs met. But because I feel like I'm an equal in that they have more training in the pathophysiology and all of that, I know my patients and I know what their priorities are and I have a more holistic picture, and so I feel like we're on equal footing and I have no barriers to go to them to advocate for the patients' needs.

### **Amelia**

Amelia was my most emotional interview as I felt incredibly taken by her story. After struggling to connect with participants through the snowball process, I received Amelia's contact information through my IPE mentor who connected me with a priceless connection; she helped bring Amelia to this study. Amelia presented, as she would have described, in a mess, but she was perfect. She had been running around all day and was waiting for one of her children to come home. Amelia had her brown hair pulled high up in a bun and had a blue t-shirt on; she profusely apologized for being "a complete mess," but what she gave me was her experience and story, and I will be forever grateful.

When Amelia described her work environment, she described how incredibly different her clinical learning environment was, reporting "I was spoiled"; she agreed that her school/work images did not mirror each other. She also reported that her clinicals were all at magnet facilities, offering the best in collaborative teaching and learning experiences, whereas in her work environment, she realized there were silos and this did not match how she learned. As she described her experience as a PICU nurse in a very diverse facility and how terrified she felt about the work environment, the essence of her experience emerged. She reported a time she thought that maybe she found herself in the

wrong environment, that maybe she should investigate other nursing positions in a more collaborative environment, as she expressed:

They need me. So my stance is to make a difference. You know, I feel like I need to make a difference. To take all the knowledge that I got and all the leadership ability that I have inside of me and say, “No, we can’t do this! No, this is an unfair setting. No, we gotta do this, we must do this.” So not to like, you know, being semi new, well, fairly new, you don’t want to make too many waves, but I got everyone on board on nights and told them, “You know we are all over-census at this point. We cannot take another one.” I had to call the resident and tell him, “Until we have the proper staff we cannot take another admission, we are not doing any justice right now.” So it was like a couple weeks in the making, but I kind of got everyone a little hyped up saying “We gotta be on the same page.” Knock on wood, it’s been working. I know the need that I have filled, my peers know it and see it and recognize it, and I have gotten—the best compliments I think that I’ve gotten are from my coworkers. “If my child ever came here, I’d want you to be their nurse.” There’s nothing better than that. That’s the ultimate compliment. One of the best compliments came during my yearly review from my nurse manager. I was asked to take on a leadership responsibility on the unit to help teach other nurses on orientation. That felt really great. As hard and unfair as the settings are at times, what I’m forced to work in, I can’t imagine working in these conditions sometimes, I almost feel like they need me. They need me.

## **Julia**

Julia was my last interview. I received her contact information from the same IPE connection who had linked me with several others in this study. Julia was a lively and enthusiastic participant to interview. Our FaceTime interview was in the morning after Julia’s workout session, and she was ready to go. She presented in athletic attire, with light brown hair pulled back into a long ponytail; she sat upright and attentive as we started the interview. Julia reported what prompted her to go to an IPE nursing school: it provided an opportunity to communicate more effectively. During her interview for her first position as a nurse, she felt much empowered by being able to say she was interprofessionally educated. She also noted that during the interview, it was apparently a

great selling point on her resume. The idea of communicating with others as a whole and working with a collaborative team has meant everything to her professionally.

So usually during rounds, I will be there with all the other disciplines, PT, OT, managers, clerks, residents, attending, and an attending will say, “You know, Julia, what do you need for this patient that we haven’t been doing?” or “What is your opinion on this plan or assessment or what do you think is going on?” They do actually really incorporate our, our opinion into the discussion of that patient. So it’s nice to know we kind of all work together to figure out what is best. It’s really great, I love it. Professionally, it makes me feel like they respect me. You know when communication doesn’t occur at some point, things are not good. So I think practicing communicating with others disciplines, other types of health care professionals, is important. I learned this during my professional education, my IPE. I know when I have a good day at work it was because of good communication.

### **Thematic Analysis**

Through the art of writing and rewriting, the researcher used the fourth step of van Manen’s (1997) phenomenology research method. The process of writing, rewriting, editing, and revising is done through meticulous connection with the stories. This in-depth writing is a process of reflection and cannot be completed without sitting with the transcripts, notes, and audiotapes several times, envisioning the themes that ultimately evolve into interpreted meanings.

A list of 12 possible subthemes was identified. In almost all of the interviews, these themes came to light and were evident. To continue with the analysis phase, specific quotes from the nurse participants were identified and collated into the theme categories. The ultimate goal is the revelation from the essential themes of which aspects or qualities make the phenomenon of the nurse who transitions into their professional role after receiving IPE: discovering what it is, what that experience is, and which, without identifying, the phenomenon could not be (van Manen, 1997).



The complete analysis process took several months of dwelling on and rereading the transcripts and listening to the interviews. To identify meaning units, I read the transcripts again and highlighted common phrases with different colors to reflect common ideas. I then listed each cluster of ideas and reviewed them with phrases moved to a different cluster according to the “fit.” I developed a spreadsheet to summarize the process and resultant information. Clusters of meaning units were then named as themes. I shared the spreadsheet and themes with my advisor and a qualitative research expert. During this phase, I made further revision of the content of clusters and changes for thematic identification. The result was a total of 12 themes. From these 12 outlined meaning units, four essential themes and nine subthemes emerged. The 12 meaning units that emerged were:

1. Empowerment,
2. Coordinator,
3. Reciprocal Teamwork,
4. Communicator,
5. Comfortable,
6. Appreciated,
7. Proud,
8. Respected,
9. Advocate,
10. Responsible,
11. Autonomous, and
12. Confident.

I then constructed a document with a list of the essential themes and subthemes that emerged and emailed it to all the participants of the study. The participants were encouraged to offer comments and give feedback to clarify any misinformation or misinterpretations. I received several emails from the participants with no concerns. One participant responded that she was “amazed with the research process and I approve of the themes you came up with”; another’s feedback included, “I agree with the findings and themes.” The final essential themes and subthemes are provided in Table 2.

Table 2

*Essential Themes and Subthemes*

Essential Themes	Subthemes
Theme 1: Understanding Team Dynamics	I. Coordinator II. Knows place on the team III. Reciprocal teamwork
Theme 2: Competent and Responsive Communicator	I. Goes up the chain of command II. It’s ok not to know everything
Theme 3: Values Team Members	I. Everyone has a role II. Everyone is valuable
Theme 4: Recognized Self-Readiness	I. Recognition of their education II. Prepared for their scope of practice

### **Establishing Rigor**

Establishing rigor as part of interpretative research is establishing and maintaining a relation to the phenomenological question of what was it like to transition into the professional role after IPE. Phenomenological research is rooted in personal interests.

According to van Manen (1997), phenomenology is a personal engagement that connects how we understand things and how we understand ourselves. Through phenomenological research, we reach the essence of in-depth understanding and thoughtfulness which gives us situational perceptiveness. As nurse educators, it is important to question and understand the experiences of new graduates and adjust pedagogically to ensure the most successful outcomes.

Phenomenological writing requires that the texts be oriented, strong, rich, and deep in order to be valid (van Manen, 1997). The researcher must orientate herself to the world of the participants by listening to and reflecting on their stories and experiences and connect strongly on a personally level. The researcher must capture the deep and rich meanings of the reflected descriptions and emerge with the essence of the experience. “Depth is the means the things have to remain distinct, to remain distinct, to remain things, while not being what I look at present” (Merleau-Ponty, 1968, p. 219). The reader will see how the researcher applied all four conditions required for phenomenological writing.

### **Essential Theme 1: Understands Team Dynamics**

All of the nurses identified that they understood what it meant to be part of the “team” from when they were being educated, and it stood out to them once they started their transition. Understanding Team Dynamics describes how these nurses realized their place in a team setting. These nurses did not have to be taught they were going to be part of a team; they understood that in order to care for patients, it took a team—a team of which they would be part. What became apparent to me was that not every nurse had the same exact players on the team, but they all reached out to the resources that were

available to them and learned the dynamics of their particular team. This theme presented itself repeatedly throughout most of the interviews. The nurses identified having learned to use their resources and understood this was part of “patient-centered” care with a “team” approach.

Three subthemes emerged: Coordinator, Knows Place on the Team, and Reciprocal Teamwork. These were synthesized to create the essential theme Understands Team Dynamics.

**Subtheme I: Coordinator.** Amanda articulated how on her first day off orientation, she was thrust into her role, but knew that she was part of a team and not alone.

You’re like the coordinator of all things that happen throughout the day and for your patients, and it’s a lot of finding, and not only finding, but using your resources; I learned early on that I’m not ever going to know everything. So knowing my resources, and then trying to coordinate the day, that’s how teamwork works.

This essential theme of understanding team dynamics came forward through examples of understanding that patient care requires a team approach, and these nurses identified that it was their role to be the leader in the team and defer to others within the team.

**Subtheme II: Knows Place on the Team.** Annabelle described her role as having to “connect” all the team members to manage patient care. She recalled a time when she understood her role in the team was to pull it all together on a daily basis, as she explained:

I always felt like the nurse’s job was to connect all the different silos because no one was really doing that, in my experience. This is how I learned. When I was in school I learned this way and it was really beneficial to know that health care has multiple different facets and we’re all going to be working together, you know, for the patient, but there’s a lack of that in the hospitals because everyone has their jobs to do. But my view of the nurse is that it is our job to connect all

those silos together because we're the only ones that know what is going on with the patient on a minute-to-minute basis.

All the nurses understood that their roles were very important for the team to work efficiently and they may have to take the lead at times. These nurses also understood that they needed to work with others on the team and collaborate.

**Subtheme III: Reciprocal Teamwork.** Lydia described what teamwork was like for her where she works and how she felt when describing what it was like to feel empowered through teamwork in her environment:

I think something that is really good that occurs in terms of teamwork where I work is that the physician and especially the residents really do appreciate the nurses' input. . . . I have been able to see fostered in this environment is that the doctors and residents value our opinions and recommendation in terms of changes that need to be made or things that need to occur. So I think that it makes it even more important and more helpful when we are collaborating, when we are voicing the concern or we're communicating about a patient, because it makes you feel like you're actually able to advocate or your concern is being listened to and your recommendations are being listened to and that's empowering. To be able to use your education, your knowledge, and your ability to critically think as a nurse to voice that to the physician with your recommendations and feel as though they are wanted, not just ignored or dismissed.

## **Essential Theme 2: Competent and Responsive Communicator**

Every participant discussed what it felt like to communicate, but what came through time and time again was the nurses' feeling that they were expected to communicate. They understood that they needed to communicate and it was okay if they did not know something. These nurses identified that they did not know everything when they first transitioned into practice, but what they did know was how to get the answers and how to use their resources through communication.

Two subthemes emerged: Goes up the Chain of Command and It Is Okay Not to Know Everything. These were synthesized to create the essential theme of Competent and Responsive Communicators.

**Subtheme I: Goes up the Chain of Command.** Heather described an experience when she needed to communicate with a resident who thought she was wrong:

There was only one time when a resident didn't listen to me when I communicated a situation and that was when I called a stroke alert, and she said, "Oh, I don't agree with your findings, cancel stroke alert," and I said, "Oh, we don't do that around here. We don't cancel stroke alerts. We'll have the stroke team come and assess him." The patient did have a stroke and it felt good to know I made the right assessment, but even if I had not, I still needed to communicate what I thought was wrong, I'm not afraid to be wrong and I'm not afraid to get help.

What the nurses described was feeling comfortable to communicate to the team members and not feeling intimidated to do so. Julia expressed that she knew her ability to communicate was never a problem, and how she was taught gave her the confidence. Christine described communication as being the most important and said, "You have to know where each of your team is coming from." She added:

You're taught to advocate for the patient, that's what you're here for, so, I don't worry, I talk to who I have to talk to. If you have to go to a little bit higher if somebody doesn't answer you, you do so, which can be a little scary, but that should never stop you from what you need to do, you're working in a hospital, you're taking care of patients. It's very rare that I don't get a response.

**Subtheme II: It Is Okay Not to Know Everything.** Lydia described how her education prepared her to communicate and that no question was a foolish one. She described how understanding how to communicate helped her while she was transitioning:

One of the things that was always stressed to me in nursing school was to never be afraid to ask questions and seek help, so I think that was something that was comforting for me as I started as a new graduate nurse, knowing that there

were always resources for me, whether it was other nurses or doctors or management, people in management. I think that it was always stressed to me to ask questions and seek help and advice, and knowing there was no question too small or too large to ask. I think that eased my transition.

### **Essential Theme 3: Valuing Team Members**

Being a part of something and realizing the value in what one brings to the team as well as valuing the other members of the team contributed to a consistent theme. To value being part of a team was realized as the nurse participants expressed understanding how they were a valuable part of a team and valued the other team members, in turn feeling valued themselves.

Two subthemes emerged: Everyone Has a Role and Everyone Is Valuable. These were synthesized to create the essential theme of Valuing Team Members.

**Subtheme I: Everyone Has a Role.** Amelia described what it was like being a “tag-team” with the other members who were an incredible value to patient care.

So I would oftentimes try to comp those activities together or work with the physical therapist and occupational therapists if I thought that I don’t know how to get this person out of bed because the last nurse didn’t know if they could walk, so I’m going to try to be there with the PT and OT so that we can all work together to try and kill two birds with one stone. I always tried to use my resources efficiently because I know that, you know, I’m only one person and they, I think that the PT and OT would agree, we work best when there’s a team approach. We all need each other, that how this works.

**Subtheme II: Everyone Is Valuable.** Many of the nurses described feeling “respected” and “trusted” and that made them feel great to be valued. Joan expressed, “It makes me really happy and proud every time someone trusts me with their patients.” Heather described how it felt to feel that the nurses and others in the team trusted her:

Their trust in me has only grown as I’ve grown as a nurse, in terms of my capabilities; they have always been so supportive when maybe I didn’t have that knowledge to begin with, at first. It makes me feel very happy and proud every

time someone trusts me with their patients to either watch them or to help assist them. That's a fantastic feeling.

Everyone has a role on the "team," and knowing that one cannot do this alone and valuing all the parts of the team came through consistently.

#### **Essential Theme 4: Recognized Self-Readiness**

Of all the themes that emerged, recognizing self-readiness came through the most consistently. These nurses expressed how their education played a significant part in preparing them for the transition into practice, and they embraced their roles and responsibilities. These participants were aware of their scope of practice and also understood their education made that possible.

Two subthemes emerged: Recognition of Their Education and Prepared for Their Scope of Practice. These were synthesized to create the essential theme of Recognized Self-Readiness.

**Subtheme I: Recognition of Their Education.** Christine described how her "training" in school encouraged her to learn more about different professions and she felt confident to do so.

I think I brought a new perspective into the work place and it increased my value as a member of the nurse surgery team. And I know I keep saying communication, but I wasn't intimidated by the surgeons or by the people who had maybe more years of education than I did. I saw myself as an equal and I wanted to learn from them, and I knew that I had things I could teach them too.

Joan described her transition as "easier" compared to those with whom she was on orientation who did not have the same education.

IPE made the transition a lot easier, it was a lot less intimidating for me than others. I feel like it's been easier for me to talk to other professionals because of the education I received and just the overall experience I had, knowing what their



practice is, what their scope is, understanding my scope of practice and how they can assist me in my own job in taking care of patients.

**Subtheme II: Prepared for Their Scope of Practice.** Roseann explained how she felt about taking on a very autonomous role upon graduation, but her education prepared her for the transition.

My case is not very typical since I went straight into being a case manager in hospice, which is a completely autonomous position. So it was terrifying, and, but I think interprofessional skills are much more important in my job than even for most nurses because I don't really work with other nurses very much. I work with my team and I am sort of the coordinator for the team as the nurse case manager, so I work much more closely with our social workers and physicians than I do with other nurses. So having interprofessional education is just, it was the most important training I had in nursing school for my job.

These nurses felt comfortable with taking on their roles because of the education they received. Lydia expressed knowing she was a valuable member of the team and how she felt like an equal member to the other professionals because of her education; as a result of that, she felt more comfortable.

I think understanding how much information I was bringing to the table as a nurse was really important. So assessment skills, I mean, is really the thing that I actually think my education did a really good job with. Assessment and diagnoses in the nursing framework. And I feel like I got good training in that, not just in how to do it, but in how to present it in a way that isn't just "here are some numbers" but "this is what I think." So a lot of training in SBAR, but things that really help you to learn how to present the data and the case to the team and I think I am much more comfortable doing that then a lot of my colleagues who didn't have the same education that I had.

### **Interpretive Statement**

The four essential themes were synthesized to create the interpretive statement, which provides insight into the phenomenon of interest. For this study, the lived experience of nurses who transitioned into practice after receiving an education with an

IPE curriculum and practice is one of understanding team dynamics as competent and responsive communicators, valuing team members, and recognizing self-readiness.

### **Summary**

Chapter V described the process of phenomenological inquiry into the lived experience of nurses transitioning into practice after receiving IPE. This select group of nurses has not been studied yet. Through reflection in the interview process, the experiences of nurses who transitioned into practice were explored. The process involved gaining contact with these nurses; interviewing them; journaling data; reading and re-reading through an immersion process and listening to their stories; and identifying themes, subthemes, and essential themes that the participants looked at for clarity. Through the analytical process, the essence of meanings as described by the nurse participants was revealed. These meanings will be discussed in Chapter VI.

## Chapter VI

### REFLECTION ON THE FINDINGS

This qualitative study was conducted to bring meaning to and attempt to describe an experience as it appears, while also understanding that all experiences are interpreted (van Manen, 1990). Phenomenology was the chosen method for this study because it provides a deeper understanding of the experience of transition into practice for nurses who have received interprofessional education (IPE). Each participant in this study viewed her experience of transitioning into practice within the framework of their education, orientation period, and work experience, while I as the researcher came to the investigation with an understanding from my own background and professional experiences. In the process of interviews and interpretation, the participants and I developed a shared understanding of the phenomenon (Wojnar & Swanson, 2007).

The process of phenomenological reflection is retrospective rather than introspective (van Manen, 1990). For the experience to be understood, it must be reflected on. The participants in this study reflected on their experiences and described what their transition into practice was like. As the participants began to reflect and then describe their experiences, they discovered how each part of their experience affected the whole experience. Through reflection, the participants brought to life what it was like for them to transition into practice.

After reflection, four essential themes were synthesized from the data:

(a) Understanding Team Dynamics, (b) Competent and Responsive Communicator, (c) Valuing Team Members, and (d) Recognized Self-Readiness. These themes were described in Chapter V and are made clearer in this chapter through explanations defined by the literature and the theoretical model chosen to understand and place the study into context. Limitations, implications, and recommendations are then addressed.

### **Synthesis of Data**

Coming together is a beginning; keeping together is progress;  
staying together is success.

Henry Ford

The quote expressed above by the Ford Motor Company founder resonated with me when thinking of the process of IPE. Getting students to “come together” is fundamentally what IPE is all about. The literature supported the idea that by learning out of silos and bringing students together from all different pre-professional programs, the professional working environment can be mirrored and the processes of collaboration and communication within teams can start. “Keeping together” is done throughout the IPE curriculum and helps the students to develop an appreciation and respect for the roles each member of the team plays in patient-centered care. “Staying together” is probably the most profound part of the quote to me because, even though these students graduate and branch off into their professional lives, IPE experiences go with them. Students may leave professors, clinical instructors, and fellow classmates, but what “stays together” is what they learned and how they learned as a team.

### **Essential Theme 1: Understanding Team Dynamics**

Participants reported understanding the importance of teamwork and collaboration during their transition and work experience, which was learned during their clinical undergraduate interprofessional education. IPE provides an opportunity for students to engage in shared leadership regarding team decision making (Ketcherside, Rodes, Powelson, Cox, & Parker, 2017). This was confirmed by the participants who had expectations of being on a team and understanding the roles they would play. According to the Interprofessional Education Collaboration Expert Panel (2011), involving students in interprofessional learning prepares them for real-world situations and how to contribute to an effective team. These participants reported often feeling like a “leader” or “coordinator” of the team, and most described feeling confident within the teams in which they were members.

The word *team* in healthcare is not new. Much of the literature on teams in healthcare revolves around the need for communication to reduce medical errors and negative health outcomes, including death (Leonard, Graham, & Bonacum, 2004). In recent years, interdisciplinary teams have become a focus on how patient-centered care is delivered. In a quantitative study by Haynes and Strickler (2014), TeamSTEPPS was a systematic approach to incorporating teamwork into practice and has been directly correlated with improved interprofessional collaboration, communication, mutual respect, and patient safety and outcome. Most of all, the nurse participants in this study were comfortable with their transition, sharing that their education mirrored the teamwork among disciplines required in hospital settings. The participants understood team dynamics and how to be part of a team by describing how gratifying it felt to work

collaboratively with other members of the team during rounding and patient care. The knowledge and experience of team dynamics are empowering and assets for new nurses who are transitioning into their professional roles.

All of the nurse participants shared stories about being part of a team during their education in some way and how, once they transitioned into their professional role, they acclimated to the team seamlessly.

### **Essential Theme 2: Competent and Responsive Communicator**

Historically, nurses were seen as handmaidens to doctors; however, today nurses are expected to communicate within a team and advocate for their patients on a leveled professional playing field (Turner, 1995). The participants understood they would not come into the profession after graduation and know all things. What they did understand was that by communicating with other team members, they could collaborate and find out how to manage the patient as they needed to. A longitudinal study by Pollard and Miers (2008) measured attitudes toward collaborative learning and professional role for new nurses who received IPE and found that these nurses were more confident with their interprofessional skills, professional interactions, and communicative skills than those nurses who had not received IPE. Until now, no one has asked nurses about their lived experience of transitioning into practice after receiving IPE. The participants in this study expressed how their education provided them with the skills necessary to communicate effectively and gave them an understanding of other professions which greatly helped them during their transition period. They also talked about competence.

All new graduate nurses are expected to be competent. The word *competent* is defined as having the capacity to function, capacity to respond (*Merriam-Webster*, 2015). According to Geoffrey Norman (1985), “Competence is a multifaceted and dynamic concept that is more than knowledge and includes the understanding of knowledge, clinical skills, interpersonal skills, problem solving, clinical judgment, and technical skills” (pp. 109-110). For the purposes of this study, competence was viewed as a behavior or a set of behaviors, such as communication and collaboration that describe how the participants communicated in an interdisciplinary manner. Participants indicated that they were aware of the need to communicate. They were not always sure if they were right or wrong, but that did not deter them from reaching out to the team for answers and help when necessary.

The word *responsive* is defined as quick to respond or react appropriately (*Merriam-Webster*, 2015). According to Harlene Anderson (2012), a “responsive practitioner is one who focuses on the notion of how particular kinds of relationships and conversations are key features to fitting our practices to the uniqueness of each person’s circumstances and are inherently transforming” (pp. 8-9). Participants knew one of their responsibilities was to be engaging actively with team members as well as with patients and family members. They also recognized how every patient is unique and requires different care and objectives; by having the proper conversations, they were able to meet goals and objectives. The relational responsive practitioner in this study was viewed as the nurse who sees herself in a relationship with other members of the team, but also in a relationship with the patient. Participants described being advocates for their patients and felt confident to go straight to the source to get help; they saw how it was their

responsibility to do so, in accordance with their scope of practice. They all described communicating with the other team members to collaborate on patient care daily and considered it part of their routine.

### **Essential Theme 3: Valuing Team Members**

The nurses talked about their appreciation of the other members of the team. They all learned to value interprofessional team work and collaboration during their IPE experiences and this carried through during their transition and work experience. This theme was centered on the respect and value that these participants expressed about other team members. The nurses knew that all participants of the team were essential to patient care. What also presented itself was the idea that not all nurse participants were educated with the same cohort of pre-professionals. One participant was only educated with physical therapy and pharmacy students, as compared to others who were educated with medical students and several other pre-professional healthcare students. What came through were the connections to the team and team-based patient care that developed during their undergraduate education, which made the difference once they transitioned into their new professional roles. Regardless of how many different disciplines they were educated with, the understandings and experiences were similar.

A study from Sweden was conducted in 2013 that surveyed newly graduated nurses from three IPE universities with varying commitments to the IPE curriculum. The findings of that study corroborated with some of the findings in this study. The Swedish study identified one of the targeted areas in IPE as cooperation with other professions. All of the respondents reported that one of the main goals of their nursing education was to “cooperate with other professions.” They concluded that recent graduates from these



IPE universities work with other professions more successfully in a team, compared to nurses who graduated from a non-IPE university. They attributed their findings to their participation in IPE education (Wilhelmsson, Svensson, Timpka, & Faresjo, 2013).

Regardless of the disciplines within each cohort and learning environment, participating nurses from both the Swedish study and this study understood the value of the other members within the team and learned this from their education.

During their education, communication and collaboration were essential parts of the curriculum, with a strong sense of respect and value for other members outside of their own profession. The respect was due to understanding the different roles within the team, but it also was due to having an understanding of the scopes of practice of other team members as well. These nurses felt connected to the other members of the team because they were familiar with them as professionals from other but related disciplines.

#### **Essential Theme 4: Recognized Self-Readiness**

Transition into practice has been studied for decades from as early as the work by Marlene Kramer (1974), who described how nurses found themselves in “reality shock” upon entry into practice. Kramer noted how new nurses felt when they learned the school world environment was very different from the work world environment. She explained that this conflict was the primary reason for reality shock and that “other primary problems that give rise to many of the other contributing factors cause reality shock, such as interpersonal incompetency, inability to bargain for identity, and lack of role negotiation” (p. 3). New nurses who graduated from traditional programs have been studied for their experiences and their difficulty in transitioning. One of the main aspects of their difficulties was feeling overwhelmed, being unable to communicate with other

key members of the healthcare team, and sensing they were not prepared (Kramer, 1974). Participants in the current study did express that they felt it was difficult to manage everything at first, but what modified the transition stress was understanding their scope of practice and confidence in interacting with other healthcare team members. They brought with them an understanding of a team approach to patient care, which allowed them to focus on their own scope of practice. Many of the nurses expressed that by understanding the other roles within the team, they could concentrate on how to manage care, anticipate what the needs of the patients were, and set and meet their goals.

### **Thematic Statement Reflection Using a Theoretical Model**

The synthesis of the essential themes resulted in the interpretive textual statement for transition into practice after receiving interprofessional nursing education. The statement is: *Transition into practice after receiving interprofessional nursing education is one of understanding team dynamics as competent and responsive communicators. They value team members and identify themselves as part of the team and being able to recognize self-readiness.* Following significant reflection on the essential themes and the interpretive contextual statement as well as an extensive literature search, Kirkpatrick's Four-Level Evaluation Model emerged as a conceptual model that shed further light on the findings from this study.

### **Relationship Between the Findings and a Conceptual Model**

Kirkpatrick's Four-Level Evaluation Model was identified as a model that could add depth to the findings of this study. This model was developed in 1959 and still serves as a highly recognized framework for the evaluation of learning and the development of

practitioners (Phillips & Phillips, 2007). Kirkpatrick's model is based on the understanding that training programs can be evaluated across four levels: reaction, knowledge, transfer, and impact (Kirkpatrick & Kirkpatrick, 2009). Although this model is used to survey participants who have been trained to determine and evaluate satisfaction with the education, for the purposes of this study, Kirkpatrick's Four-Level Model was used to further understand and contextualize the question and essential themes that emerged. The findings of this study were connected to each of Kirkpatrick's four levels. These connections provide a framework for the findings of the study.

### **Level 1 Evaluation: Reactions**

Kirkpatrick's Four-Level Model identifies Level 1 as the measure of how participants in a training program react to it, meaning how did what they learned transfer into their work environment. These outcomes relate to participants' views of their learning experiences and their level of satisfaction as related to their current job (Kirkpatrick, 1996). This level of Kirkpatrick's Four-Level Model speaks to all themes in the findings in this study.

In Essential Theme 1, Understands Team Dynamics, these nurses received education with cohorts of other pre-professional students with whom they would likely collaborate in practice. Essential Theme 1 relates to Kirkpatrick's Reaction Level because the participants talked about knowing that they would be part of a team and what it meant to be part of a team because of how it was enforced during their education. What they learned during the pre-work socialization period was realized during their transition into the practice period. Participants expressed a sense of understanding during their transition into practice that collaborative practice would be part of their role.

In Essential Theme 2, Competent and Responsive Communicator, participants described the importance of communication among the disciplines. They were expected to communicate among the disciplines during their education as well as once in practice. Many described how their education facilitated their ability to communicate and advocate competently, and they felt comfortable doing so as a part of their professional role. Essential Theme 2 relates to Kirkpatrick's Reaction Level because communication among all the students was fostered and developed throughout the curriculum and clinical experiences with students from other disciplines, thus mirroring what they experienced in professional practice.

For Essential Theme 3, Valuing Team Members, participants described this as understanding the roles of other members of the professional team and learning with other pre-professional students. They also described how they had a significant appreciation for the other members. They described feeling confident about reaching out to other members of the team because they understood their scope of practice within the patient care team. Essential Theme 3 correlates with Kirkpatrick's Reaction Level as a result of experiential learning about the roles of the other healthcare team members as well as the value of each team member.

In Essential Theme 4, Recognized Self-Readiness, participants recognized that their education prepared them for the work place environment and significantly prepared them for their transition into professional practice. They recognized how they were prepared to understand their own professional scope of practice better than those nurses who had not received IPE. This directly relates to Essential Theme 4 and how these nurses used what they learned immediately upon transition into their professional role.

These feelings of knowing their place on the team, advocating when necessary through proper communication, valuing other members of the team, and recognizing their scope of practice confirms Kirkpatrick's Level 1 category of learners' reaction resulting from their training/education.

### **Level 2 Evaluation: Learning**

Level 2 (Learning) measures the knowledge required, skills developed or improved, and/or attitudes changed as a result of the program to move beyond satisfaction and assess advances in skills, knowledge, or attitude (Kirkpatrick, 1996). This level speaks to all of the themes that emerged throughout this study as well. Typical measures captured at this level include but are not limited to skills, knowledge, capacity, competencies, confidence, and contact (Phillips & Phillips, 2007). Although this study did not look at the knowledge the participants had before IPE, what did come through in the study was their level of abilities because of their education, and this had a tremendous positive impact on their transition into practice.

In Essential Theme 1, Understands Team Dynamics, these nurses had the experience of being part of a team during their education tenure. One of the subthemes that came through was reciprocal teamwork because these nurses had learned how to work together throughout their IPE. They brought with them skills and the capacity to see the team dynamics and what teams meant. The other subtheme that related to this level was coordinator. Participants described how they transitioned from orientation and were thrust into their roles almost immediately, but because of their education, they knew how to navigate the resources well. This essential theme and these subthemes relate to

Kirkpatrick's Learning Level because here, participants' knowledge and skill level are evaluated at a higher level after implementing what they learned during their education.

In Essential Theme 2, Competent and Responsive Communicator, nurse participants described themselves as advocates. They all expressed having an experience, and the subtheme that resonated with a higher level of knowledge and skill related to education was Goes up the Chain of Command. These nurses were very confident in communicating their needs as well as the needs of their patients. They expressed not knowing everything, but they knew how to get the answers they needed and were not afraid to reach out for help or go above the heads of those they felt were not giving them the help they needed. During the interviews, they described reaching out and working collaboratively with other team members during patient care and how this mirrored what they learned during their IPE.

The Essential Theme 3, Valuing Team Members, came through and correlates within the higher-level skills and knowledge of Kirkpatrick's Level 2. Nurse participants described bringing other members into the care of their patients as new nurses during their transition period. They had confidence and trust in the other team members to "tag-team" during patient care. Their attitudes and how much they valued other team members were significantly related to how they were educated as they described understanding the cohorts of students with whom they learned and how they brought that understanding into their transition period. They were all educated to use and value their resources and team members—a finding that came through very clearly during this study.

Essential Theme 4, Recognized Self-Readiness, relates to Kirkpatrick's Level 2, Learning, by the competence and confidence the nurses had in their scope of practice, so

much so that they could concentrate more on their role and how to manage patient care effectively. They described themselves as having a sense of confidence that allowed them to be more autonomous. This match in findings demonstrated how well aligned the conceptual framework was to the study, as well as how this study's findings on patient outcomes and teams were consistent with the literature, because these nurses exhibited higher skills and knowledge than those from a traditional nursing program.

The participants in this study did show a higher level of skill, knowledge, and attitude towards team-based patient care, as well as feelings of confidence that allowed them to act more autonomously. This was directly related to understanding their roles and scope of practice, which they had learned during their education.

### **Level 3 Evaluation: Transfer (Behavior or Application of the Learning)**

Kirkpatrick (2006) described this level as how to measure the extent to which changes in participant behavior occur because of the education. Evaluating at this level attempts to answer the question: Are the newly acquired skills, knowledge, or attitudes being used in the everyday environment of the participant? This level is aligned with the study question of what was it like to transition into practice because it asked the participants to reflect on their transition into practice after having received IPE. Typical measures captured at this level include but are not limited to extent of use, task completion, frequency of use, action completed, success with use, barriers with use, and enablers to use (Phillips & Phillips, 2007). The overall intent of gathering data at this level is to ask the question: "Has the student applied the skills learned?" (Plant & Ryan, 1994).

All the essential themes that were brought to light in this study speak completely to Kirkpatrick's Level 3, Transfer. Participants described in detail how they used their IPE during their transition period and beyond, specifically in how they were recognized because of their education. Every participant described using what she learned in her everyday work environment, while many of them described being put in leadership positions because of their IPE.

Essential Theme 1, Understanding Team Dynamics, correlates with this level as these nurses described being part of the team and often became the coordinator of the team. This meant they were asked their opinions and led discussions on patient evaluations and goals. As a result, they felt empowered and expressed feeling very prepared to work with other disciplines on an equal ground. Moreover, they felt enabled by their education to meet many of the demands that have stifled nurses in the past during their transition period.

Essential Theme 2 and 3, Competent and Responsive Communicators and Valuing Team Members, are directly related with Kirkpatrick's Level 3, Transfer, because these nurses identified themselves as being able to make change and positively impact patient care because of communication. Some nurses described situations in which they directly impacted patient outcomes by being able to assess patients competently as well as communicate responsively about the help they needed to other members of the team.

Essential Theme 4, Recognized Self-Readiness, significantly relates with Kirkpatrick's Level 3, Transfer, because not only were these nurses aware of their own abilities, confidence, autonomy, and scope of practice, but they were also hand-selected



by administration to be leaders during their transition period. Some nurses described how being in an interview and receiving IPE were benefits because they were offered positions for which their IPE experience was a significant hiring factor. A few nurses were offered internship positions because they were entering with IPE experience which was desirable to the nurse recruiter. One nurse explained that once off orientation, she was given the opportunity to help with new nurse orientees in the OR where she worked because of her leadership abilities.

These findings supported the study's themes and subthemes relating to Kirkpatrick's Level 3, Transfer, as coordinating within the team, communicating with other disciplines, and valuing all members of the team while recognizing their own scope of practice and fitting into the overall team-based approach to patient-centered care, while also being recognized by peers and management as a positive influence wherever they worked.

#### **Level 4 Evaluation: Results (Outcomes)**

Level 4 (Results/Outcome/Impact) measures the extent to which a learning initiative has contributed to the work environment and objectives. According to Plant and Ryan (1994), the overall intent to data gathering at this level relates to the question: "What benefit has the organization derived?" Typical measures captured at this level include but are not limited to changes in productivity, quality, time efficiency, customer satisfaction, and employee engagement (Phillips & Phillips, 2007). This level directly relates with the literature on TeamSTEPPS, the two reports from IOM (*To Err is Human* and *Crossing the Quality Chasm*) on the vision for patient safety and the future of healthcare, and the WHO's 2010 report, *Framework for Action on Interprofessional*

*Education and Collaborative Practice*, on patient outcomes and the need for practice-ready practitioners. To achieve this, learning can play a significant role in developing our students to be participants in healthcare teams that can lead to better patient outcomes. The transfer of knowledge learned into practice to better patient outcomes and the healthcare delivery system is linked to IPE and the findings of this study.

The Essential Themes that can relate to Kirkpatrick's Level 4, Results, are Essential Theme 2, Competent and Responsive Communicators, and Essential Theme 4, Recognized Self-Readiness. For this study, the themes that related to this level dealt with the participants' perceptions of the impact they made on patient relationships and care. The need for further research related to organizational impact and benefits from students who receive IPE and become employees remains to be seen.

Essential Theme 2, Competent and Responsive Communicators, as it relates to Kirkpatrick's Level 4, Results, for this study looked at the participants' perceptions of how their communication directly impacted patient care and outcomes. Through the literature, it was understood that most errors happen when there is a lack of communication (JCAHO, 2017). In this study, nurses expressed feelings that they made a difference by communicating with patients and other team members while providing team-based patient-centered care. They directly related their understanding of how to manage patient care from their education.

Essential Theme 4, Recognized Self-Readiness, as it relates to Kirkpatrick's Level 4, Results, for this study also looked at the participants' perception of how their understanding of their role, scope of practice, and assessment skills directly impacted

patient care. In this study, nurses described feeling very proud and powerful to have an understanding of their scope because of how they were educated.

Of the themes in this study that resonated with this level was Theme 2, Competent and Responsive Communicator, and Theme 4, Recognized Self-Readiness. These nurses understood their need to communicate for patients by being an advocate. Subtheme I, Goes up the Chain of Command, came through with every participant describing a time they needed to go “above the head” of another team member. This created a sense of empowerment because they were not afraid to advocate when necessary. All of the participants in this study felt they greatly impacted patient outcomes on a daily basis. These nurses recognized their readiness to be actively engaged and expressed how they knew they made a difference. They attributed their ability to stand up and advocate when necessary and know their scope of practice to their education.

### **Limitations of the Study**

This study had several limitations. Qualitative research findings cannot be generalized; therefore, the findings of this study represent the lived experiences of the 10 nurse participants. This study was limited to female participants in part because of the low percentage of male nurses in the profession as well as the potential participants who volunteered, none of whom were male. There are also a limited number of programs and a great variation of the extent of IPE experiences. Another potential limitation might be the differences between face-to-face interviews and those conducted using FaceTime. It would have been preferable for all interviews to be face-to-face interviews because it is difficult to experience the interview process thoroughly from a small window with miles

between the participant and myself. I did not feel the interview was as personable and might have in some way conveyed this feeling. While I worked to bracket my own biases and assumptions of experiences, the possibility still remains that my own interpretations could have altered the participants' responses because of my own experiences and preferences for working in a collaborative work environment.

### **Implications**

The aim of this study was to illuminate the meaning of the experience of transition into practice of nurses who had graduated from a program rich in interprofessional education experiences. The analysis of the transcripts of the nurses' interviews shed some light on their transition into professional practice.

Many implications can be identified from this first look at the lived experience of nurses transitioning into practice after receiving interprofessional education. As mentioned earlier, transition into practice is not a new concept; however, the experience of transition into practice after receiving IPE is supported by the research (Interprofessional Education Collaborative Panel, 2011; Josiah Macy Jr. Foundation, 2013; Speakman & Arenson, 2015; WHO, 2010), all introduced earlier in this study. The above-mentioned authors have done extensive research on IPE and the need to change the way nurses and other pre-professional students are educated to mirror the clinical work environment. The participants all learned with and from other members of pre-professional students and developed a sense of team by learning how to communicate effectively and collaborate together, thus positively impacting their transition into practice.

One of the most important implications of this study is that the number of cohorts with whom the participants learned did not matter; rather, the important point was to learn outside of traditional education silos and with other members of a team of whom they would inevitably be a part in real practice. Participants had an opportunity to expand their understanding of patient care during their education that mimicked a collaborative team approach to patient care—and this is remarkable. Nurse educators have a duty to understand that there is a need to explore this type of education because there is also a fundamental need to help nursing students become better communicators within a team. The nurses in this study made it apparent that their education significantly helped them to transition more easily and be better nurses than those with whom they shared orientation and who did not have the same education.

Research has supported the need for nurse educators to “step up” and do more during undergraduate education for many years in order to prepare new nurses for their transition into practice to achieve higher retention rates, job satisfaction, and self-confidence (Benner, Sutphen, Leonard, & Day, 2010; Dyess & Sherman, 2009). From previous research that identified the need for IPE and the newly identified data from this study, it can be implied that IPE improves retention rates because all of the participants were in the same positions and/or institutions where they first transitioned. It can also be implied that nurses who received IPE have higher job satisfaction and self-confidence because their professional role mirrors their education. Participants were very confident in their role and scope of practice, thus implying that nurses who are confident will also be satisfied with their job.

One of the most important qualities identified was a teamwork mentality and the ability to understand team dynamics. Teamwork was developed during their education, and the reciprocal communication skills they learned helped them become comfortable not only with being a leader but also a follower of decisions. In this regard, this study could imply that having the ability to communicate and understand team dynamics is a quality and characteristic that nurses may possess when receiving experiences rich in IPE.

Another implication drawn from this study relates to hiring and marketability as well as career opportunities when based on having an interprofessional education. Many of the nurses expressed how nurse recruiters were impressed that they had IPE on their resume when they interviewed for positions. Some of the nurses also expressed how they were put in leadership positions early on because they were more capable of the responsibilities and their education experience was a factor in this advancement. This study could imply that IPE graduate nurses have an advantage in hiring because of their education as well as in advancing or expanding their roles and positions.

The meaning of these nurses' lived experience of transition into practice after having IPE experiences provided findings with interesting and meaningful implications. This study supports the conclusion that nurses who receive IPE have an overall better transition into practice experience.

### **Reflections on Researcher's Experience**

As a nurse educator since 2009, I have worked on two sides of the nursing profession, which helps me understand how frustrating it is to be both a new nurse and an

educator. In 1997, I became a graduate nurse, and I can recall transitioning: being petrified and not always knowing how to manage my day, who to turn to, and how to manage patient care. It was a difficult transition for me, even though I had experience working in a hospital for several years as a nurse technician and then as an LPN before I graduated. I worked full-time while I completed all my prerequisites, and once the full-time nursing courses started, I worked evening shifts at the hospital on the weekend and holidays. I understand the commitment, but I also understand how hard it is to transition.

Being a nurse educator is difficult. There is a feeling that one has not prepared one's students adequately for the real world of the profession. As an educator, I try to stay current in the ever-changing world of healthcare to ensure my students receive the most up-to-date information, but it is still daunting. I have attended conferences to broaden my education horizons so that I may deliver pearls of wisdom to students to take with them once they graduate. But my efforts never feel as if they are enough.

During this study, I had many realizations. I realized what brought me to this experience and what made me want to know more about interprofessional education. I was deeply interested in understanding communication and why, specifically, we as health professionals are not communicating effectively. That question encouraged me to find the root, where I could start from, and it led me to IPE. This study opened my eyes to where I see myself in this wonderful matrix of interprofessional education. Currently, I work as a nurse educator in a traditional program. I now introduce "teams" to my students and we discuss at length how it will feel to be working with teams—but that too is not enough. My work has only just begun here because I know there is so much more I

can give to my students as a nurse educator. Moreover, as a university, we owe it to students to provide them with an education that mirrors their real work environment.

While interviewing these nurse participants, I felt very inspired because I saw something in them that I did not possess while I was transitioning. I saw such confidence and pride in how they understood their roles and responsibilities. They spoke passionately about their profession, and their stories about being an advocate resonated with me, but I do not recall having this kind of power and conviction so early on in my career. It made me realize what the major difference was and how happy I was to find IPE. These nurses are strong and passionate, full of energy and pride about this profession, and it gives me great joy to know they are part of the profession I honor and respect so much.

As a nurse and a nurse educator, I clearly understand what my life's work is meant to be. I am meant to mentor and guide the next generation of nursing excellence and I truly believe IPE will be part of that work. This study has solidified the need to bring interprofessional education experiences to all pre-professional students, regardless of the programs or majors to which they matriculate.

### **Artistic Expression**

According to van Manen (2014), data analysis includes examples not only found in the written word, but also found in the manifestations of other senses. A picture is able to provide an image of the essence of a phenomenon. A fictional story can provide clarity and enlightenment to the themes that emerge. The image below is an attempt to bring greater clarity to the phenomenon examined here.





*Figure 1. Transition*

The image of the transition from caterpillar to butterfly, emerging from the chrysalis, illuminates the essence of the nurses' lived experience of transition into practice after having IPE. The transition process for these nurses was not met without challenges, but they were armed with ability and perseverance. The road of the caterpillar is not easy either. Like the nursing student, the caterpillar has to keep moving forward to come to its transformation. The nurses brought with them knowledge of team dynamics, effective communication, value and respect for other professions, and understanding of their role as nurses.



*Figure 2. Teamwork*

There is no “I” in teamwork. One of the many aspects of understanding the team dynamics that resonated throughout this study is understanding that it takes many team members and one conductor (see Figure 2). However, the baton that the conductor holds to lead the team is eventually handed off to other team members, who will then take the lead for the team when necessary. Each participant in this study expressed valuing other members of the team and appreciated learning *about* them as well as *from* them during their education.

### **Recommendations for Nursing Education**

As a nurse educator, it has been exciting for me to learn about the possibilities of interprofessional education and how to bring IPE into almost any learning environment. Nursing educators are always trying to keep on top of changes in healthcare and bring that information into the classroom. The recommendations stimulated from this study represent what was identified from listening to the stories of nurses who have been through a variety of IPE experiences. Learning with and from other preprofessional students is beneficial to learners during their education as well as during their transition into practice, but learning can take many forms. In this study, no two IPE programs were exactly alike, but what came through were the benefits of learning with other members, regardless of how the cohorts were blended.

The WHO in 2010 expressed the need for healthcare professionals to be “practice-ready,” meaning ready to manage patient care in a collaborative way once in practice. IPE is recognized as a way to develop communication and collaborative practice and prepare students to be practice-ready. Nursing educators should look into their own

colleges and universities and reach out from the “silos” in which they may be teaching to start conversations about IPE. Any educator who is teaching in a college or university that offers healthcare-based programs can start by having Career Days and using those times to bring cohorts of students together to join in these conversations. It is imperative to break down barriers to communication. As educators, it is our duty to lead by example and reach beyond our silos to become more collaborative ourselves.

Interprofessional education does not have to occur only with students in nursing, medicine, or other allied health programs, just as the work environment is not made up of only these professionals. Being creative with multiple programs at any institution that can be collaboratively blended may mark the beginning of fruitful IPE experiences, which will enrich students’ education by developing their communication and collaboration skills and adding quality and scope to their education experiences.

### **Recommendations for Further Study**

This research revealed one possible meaning of the lived experience of transition into practice after receiving IPE that has significant implications for future research. This study has opened many doors for future research in nursing in both education and practice environments. Despite the extensive research on the transition into practice for nurses who have graduated from traditional nursing programs, there is insufficient research on the transition into practice for nurses who have graduated from a program rich in interprofessional education experiences. Further research is necessary to identify the impact that IPE has on nurses and patients and what can be learned from their

experiences. Do nurses who receive IPE excel and advance within the profession as a result of their education? Is nursing better with IPE in it?

Replicating this study to identify the experiences of male nurses who have transitioned into practice after IPE as well as other professions who also have received IPE would be beneficial. Do other pre-professional cohorts have the same experience transitioning after IPE?

A future quantitative study to identify patient outcomes relating IPE experiences and team-based patient care would be very valuable. It is important to measure this form of education and its direct impact on patient satisfaction and outcomes.

Finally, a longitudinal study is warranted to identify if IPE has made lasting effects on those professionals who received it and whether there are long-term benefits, both professionally and with patient outcomes. This is undoubtedly an area where future research would be of great interest and value.

### **Summary**

This chapter synthesized the data into a thematic analysis supported by a theoretical model representing Kirkpatrick's Four-Level Evaluation Model. Limitations of the study, implications, and recommendations for nursing education and for future study were discussed. As well, reflection on the researcher's experience, including visual displays as clarifying examples of the phenomenon of the transition into practice after receiving interprofessional education, concluded this study.

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Appendix A  
Inclusion Criteria

Criteria	Met
1. Female professional nurse.	
2. Graduate of a 4-year baccalaureate nursing program with Interprofessional Education experiences.	
3. Transitioned from graduate nurse to professional role in a hospital or healthcare setting.	

## Appendix B

### Informed Consent

Teachers College, Columbia University  
525 West 120<sup>th</sup> Street  
New York NY 10027  
212 678 3000  
[www.tc.edu](http://www.tc.edu)

### **INFORMED CONSENT**

**DESCRIPTION OF THE RESEARCH:** You are invited to participate in a research study on the phenomenon of Transition into Practice: Understanding the Impact of Interprofessional Education on Graduate Nurses Transition into Clinical Practice. You will be asked to describe your experience of transitioning as a new graduate nurse into clinical practice. You will be asked to reserve approximately 60-90 minutes for the interview. The interview will be done face to face or by FaceTime or Skype in a private and quiet space. The use of an audiotape will only be employed for transcription after the interview. You will have a chance to see the transcribed interview and correct or add to it as needed. The researcher, Michelle McFee Romano, RN, EdD(c), will conduct the research study. The interview will be audio-taped, encrypted and transcribed by a CITI certified transcription agency. The research will be conducted at a convenient, quiet and private location mutually decided upon by the researcher and participant.

**RISKS AND BENEFITS:** There is minimal risk associated with this study. Some risk includes any distress that may be caused by reflecting on your past undergraduate experience or transition experience. There are no direct benefits to you. At no times during the research study, or afterwards, will any identifying information about participants be released. There are no direct benefits to participants as a result of this study.

**PAYMENTS:** You will not be financially compensated for your participation in this study.

**DATA STORAGE TO PROTECT CONFIDENTIALITY:** To maintain confidentiality and protect the privacy of the participants, all data collected for this study will be stored in a lock file cabinet and stored in my home. All audio tapes will be labeled with an identification number and the date of the interview so the participants name will not be connected to any audiotape. The transcripts of the interviews, along with the list of participant codes, and audiotapes will be kept in a separate, secure location locked within the researcher's home. Any transcripts and other study documents reviewed by computer will be done on a password safe computer. This procedure will be followed to preserve

confidentiality. As per research policy, upon completion of the study, all participant information will be shredded and destroyed after seven years.

**TIME INVOLVEMENT:** Your participation will take approximately 1.5 hours for the interview process and approximately the same amount of time (1.5 hours) for any additional communication necessary between you and me. This is to include the following:

- One demographic sheet at the beginning of the interview
- One 1.5-hour audiotaped interview with the researcher

Total participation is expected to take approximately 1-2 weeks.

- One follow-up email or phone conversation/review of transcript of the transcribed audiotape by interviewee with feedback provided to the researcher

**HOW WILL RESULTS BE USED:** The results of the study will be used for my dissertation, as well as potential conferences, publications, and journal articles related to the study.

Appendix C  
Demographic Data Form

Participant Number Code: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Current Age: \_\_\_\_\_ Year of IPE BSN

Graduation: \_\_\_\_\_

Name of IPE Undergraduate

College/University: \_\_\_\_\_

Professional Cohorts you learned with during your undergraduate IPE: (example: PT, OT, Pharmacy, and Medicine, or other).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Is this your first professional nursing position: Y/ N

Any Interprofessional/Team education during work orientation: Y/ N

Have you received any additional formal education or certifications: Y/ N

Current Nursing

Position: \_\_\_\_\_

Have you held a previous nursing position? Y/ N



## Appendix D

### Participant's Rights

Teacher College, Columbia University  
525 West 120<sup>th</sup> Street  
New York NY 10027  
212 678 3000  
WWW.tc.edu

### **PARTICIPANTS RIGHTS**

Protocol Title: Transition into Practice: Understanding the Impact of Interprofessional Education on the Graduate Nurses Transition into Clinical Practice

Principal Investigator: Michelle McFee Romano, RN, EdD(c)

- I have read and discussed the Research Description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- The researcher may withdraw me from the research at his/her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's study specific phone number is (xxx)xxx-xxxx, and email (\_\_\_\_\_).
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board/IRB. The phone

number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120<sup>th</sup> Street, New York, NY, 10027, Box 151.

- I should receive a copy of the Research Description and this Participant's Rights document.
- If video and/or audio taping is part of this research, I ( ) consent to be audio/video taped. I ( ) do NOT consent to being video/audio taped. The written, video and/or audio taped materials will be viewed only by the principal investigator and members of the research team.
- Written, video and/or audio taped materials
  - ( ) may be viewed in an educational setting outside the research.
  - ( ) may NOT be viewed in an educational setting outside the research.
- My signature means that I agree to participate in this study.

Participant's

signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

#### Investigator's Verification of Explanation

I certify that I have carefully explained the purpose and nature of this research to \_\_\_\_\_ (participant's name) in age-appropriate language. She has had the opportunity to discuss it with me in detail. I have answered all of her questions and she has provided the affirmative agreement (i.e. assent) to participate in this research.

Investigator's

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_